Bradford (J. T.)

REPORT.

SELECTIONS FROM A REPORT ON OVARIOTOMY, *read before the Kentucky State Medical Society, at its annual meeting at Louisville, April*, 1857. By J. TAYLOR BRADFORD, M.D., *Augusta, Ky.*

"Go to the Parthenon and find, not what bunglers, but what great men have left undone."—SCULPTOR TO HIS PUPIL.

A WORD OF EXPLANATION.—To you, members of the "Kentucky State Medical Society," who have confided to my humble ability a "Statistical Report on Ovariotomy" (I say *statistical*, implied though it may be, for ovariotomy is now a question of facts and figures, not of idle speculation,) a word of explanation is justly due, as well as to myself.

For two years my leisure moments have been employed in the collection of statistics on ovariotomy, and few of you, who have not been pioneers in a newly settled territory, but have traveled upon a beaten track, where the *finger board* has pointed out the way, are aware of the labor it has cost me. The writing of a report is a small matter, but the collection of material upon a subject, about which so little is known, is, by no means, an easy task.

But to the explanation. I adopted Dr. Atlee's tables of 222 cases as a basis for my report, and up to January had registered, including his table, 289 cases. About that time, Dr. Lyman, of Boston, very kindly sent me his "prize essay, just published by the Massachusetts State Medical Society," and to my unexpected surprise, *it contained three hundred well-reported cases of ovariotomy.* I can not express to you my feelings at that moment; it was but too evident, at a moment's glance, that both he and myself, for many a weary hour, had been laboriously at work for the same purpose, and collecting materials from the same source. And perhaps I, better than any one of you, ap-

preciate the immense labor, the collecting and classification of his cases, cost him. I examined the report carefully, and found that he had collected 11 cases which I had not, and I had collected 20, including Mr. Clay's unpublished cases, which he did not have, my 20 being principally unpublished cases. After a short correspondence with Dr. Lyman, and no little reflection, as to what would be the better course to pursue, I have concluded as a supplement to this report to adopt the nalysis of Dr. Lyman's 300 cases.

This singular coincidence, so far as I am personally concerned, is not without its regrets. But to this society, among the first, if not the very first, in this country, to call for a report of statistics, I felt anxious, so far as my ability could be exerted, to present a report, which would not only be worthy of the society, but creditable to myself. And whilst I, as your servant, regret yielding precedence to Dr. Lyman, after so much labor on my part, I confess sincerely, and with all due credit, that up to this period, no writer has performed the task so well as he.

With the exception of the chapter on the diagnosis, I have, therefore, in this short time, had to write a new report, or reverse a principal in that school, of which I am a pupil, "that true magnanimity does not consist so much in never falling, *but in always rising when we fall.*"

The interest of the present report will consist principally of—

1st. A short history of Ovariotomy and the principal operators.

2d. Diagnosis, and its errors.

3d. Letters from Professors Gibson and Atlee, of Philadelphia; Clay, of Manchester, England; Mussey and Blackman, of Cincinnati; Miller, of Louisville, Ky.; Saml. Cartwright, of New Orleans, La.; and Dr. B. W. Dudley, of Lexington, Ky.

4th. Statistics of all the operations performed in Kentucky, with a short notice of each case.

5th. Operations with which I have been connected, with here and there, throughout the report, some practical allusions.

REPORT ON OVARIOTOMY.

Perhaps no branch of surgery, for a period of time, so completely divided the members of the profession, both in Europe and in this country, or created a more vehement and bitter opposition, than did the operation of ovariotomy.

It has been regarded as a monstrous innovation upon the legitimate principles of surgery; and the defects and errors of diagnosis have been seized upon by its opposers with a "leopard-like spring of energy," which is seldom met with in the "healing art."

And here (as I do not expect to write an essay on ovariotomy,) I trust you will pardon me for alluding to a report —— on surgery, read before this society in 1854. It may be remembered that the reporter, ——, in his allusion to the operation of ovariotomy, denounced the operation and operators with a fierceness which would seem to interdict that well-established principle of philosophers on all subjects—that an honest difference of opinion may exist; and that until the light of reason has clearly demonstrated the folly and preposterousness of such opinions, there is due that amount of courtesy which becomes the liberal investigation of truth.

The tone of medical journals the past few years, and the march of public opinion in favor of ovariotomy, may have taught you that the operation has outlived the scrutiny of that report.

There are but few improvements in science, which, in their struggle for legitimacy, have not their opposition.

Even the immortal Jenner, whose discovery of vaccination links with his name the brightest remembrance of the past, met with opposition; and it was written in books, and by the wayside, that they who were vaccinated must of necessity be "converted into brutes; that children sprouted horns, others had the hair of calves" and that it infused into the system the constitutional diseases of those from whom the virus was taken.

Dr. Simpson's discovery of chloroform, that Messiah-like unction which hushes into repose the most severe pain, also had its

opposition, and the physician who would use it, was considered as "breaking alike the laws of nature and of God."

There still exists in the minds of some of the profession a contrariety of opinion, as to whom the credit of the first operation is justly due. So far back as 1782, Dr. L'Aumoner, of Rouen, has the credit, according to Mason Good and Mr. Brown, of Europe, and Dr. Atlee and Dr. Lyman, of this country, of performing the first operation for ovariotomy.

Dr McDowell's operation, as you well know, was performed in 1809. Now, let us examine and see which is ovariotomy, and whether, as Professor Gross says, the case of L'Aumoner is any thing more than an "abscess of the ovary, consequent upon parturition."

I quote the case of L'Aumoner as reported by Dr. Lyman: "The disease," he says, "appa ently followed delivery; had obstinate diarrhœa, and a *purulent discharge* from the *vagina*, *increased by pressure* on the tumor. Incision four inches, along lower edge of obliquus externus, and scirrhus ovarian cyst, the size of an egg, was found in connection with an abscess, which was tapped, and a pint of dark fetid pus issued from the Fallopian tube, with which the ovarian abscess communicated. The adhesions were torn away between the tube and the ovary, and the latter removed. No ligature used. The cavity of the abscess was filled with lint, dipped in the yolk of an egg and in honey. Suppuration of the abscess ceased the 20th day, and she left the hospital well.

The well-known case of Dr. McDowell was Mrs. Crawford. Incision nine inches long, and made on the left side of the median line, some distance from the outer edge of the straight muscle. As soon as the incision was made the intestines gushed out on the table, and so completely was the abdomen filled by the tumor that they could not be replaced during the operation. A ligature was applied around the pedicle, tumor opened, and 15 pounds of gelatinous fluid removed; pedicle divided, and sac, etc., extirpated. The whole tumor weighed twenty-two pounds and a half. In five days Dr. McDowell found her making her bed, and in twenty-five days she went home well.

You will recollect, that in the case of L'Aumoner, no ligature was applied, simply an incision made in the abdomen, and the

abscess tapped. It is not fair to presume, that when a purulent discharge was issuing from the vagina, and the discharge increased by pressure, with a tumor so small, that the incision in the bowels was for any other purpose than the simple operation of paracentesis, or to ascertain the real cause of the disease.

In Prof. Gross' Report on "Kentucky Surgery" to the State Medical Society in 1852, I beg leave to refer you for such information as relates to the early history of ovariotomy in Kentucky, and for an interesting biographical sketch of Dr. Ephriam McDowell. I have alluded to the cases of Dr. McDowell and L'Aumoner, from the fact, that from one or the other, we are to date the memorable epoch of ovariotomy.

It is difficult to ascertain how often our renowned Kentuckian (Dr. McDowell) operated; some of his relatives say thirteen times—of eight operations there is an authentic record, and of these seven were successful; in two, the tumor was not removed, and in one there was no tumor found; this last, however, was a case of his and Dr. Smith's, which, if included among his cases, would make nine operations.

Such success in a difficult and dangerous capital operation, just springing into existence—without precedent or a foot-print where the son of man had trod—is without its equal, and shows the operator to have possessed a happy union of courage and prudence.

Dr. McDowell's success in other departments of surgery was equally signal. He is said to have operated thirty-two times for stone, without losing a case. One of his patients was President Polk, whose operation took place prior to his election to Congress. Dr. McDowell was remarkably cautious in the selection and preparation of his cases; and, to this fact, together with his steady hand and accurate anatomical knowledge, may be ascribed much of his success. It is a singular fact, that Dr. McDowell always operated on Sunday morning, giving as a reason, that he always "liked to have the prayers of the church."

He was a liberal and charitable man, and his fees were generally regulated by the ability of his patients. On one occasion he agreed to operate upon a lady near the Hermitage, in Tennessee, for five hundred dollars. After the operation was completed and he was about to return home, he was presented with a check for fifteen hundred dollars.

This is, perhaps, the most princely fee which any surgeon has obtained, either in Europe or this country, if we except the thousand guineas paid Sir Astley Cooper for an operation performed in the West Indies. I have read, some where, that the learned Apono, of Pabrea, refused to visit Pope Honorius IV. without receiving four hundred ducats for each day's visit.

In an operation for stone, I once had the honor of holding the staff for Professor S. D. Gross, of Philadelphia, for which operation he received one thousand dollars.

Dr. Gross, from whose report I have taken most of the above incidents, thus sums up Dr. McDowell's character: "*He was a deep and original thinker, a bold, fearless, intrepid, and original operator; a faithful and adroit physician, an honest, upright, conscientious and benevolent man, whose career, in whatever aspect it may be contemplated, affords an example worthy alike of our admiration and imitation.*"

The remains of Kentucky's "first great surgeon" sleep in the burial ground of Gov. Shelby, five miles from Danville. Some time since, while on a visit to the interior of Kentucky, my curiosity led me to visit this memorable spot, and while looking upon the modest and plain marble slab which bears the simple inscription "Ephriam McDowell," I felt as if at the grave of one whose sacred labors were worthy of my pilgrimage hither; and as memory wandered back to the period of his first ovarian operation, when the incredulous scoffs of the first English surgeons, and the caustic derision of the "London Medico-Chirurgical Review," together with the refusal of Dr. Physic, the "father of surgery," in our own country, to publish or read to his class a copy of Dr. McDowell's operations; I could but feel a becoming pride, that the "backwoods Kentuckian" (as Dr. James Johnson styled him) had triumphed.

The success of our distinguished Kentuckian in private practice, as in surgery, had few if any equals; and while I listened in his own town to those who knew him well, I was never so forcibly reminded of the skill of Him who "cleansed the leper, opened the eyes of the blind, and unstopped the ears of the deaf"

DOCTOR LIZARS.

Next to our renowned Kentuckian appears Mr. Lizars, of Edinburgh, who, in 1823, first attempted the operation

in Edinburgh. He operated by the long incision, after the manner of Dr. McDowell. One, out of his four cases, recovered. His first case was examined by the most learned men of Edinburgh, and, after agreeing that it was an ovarian tumor, Mr. Lizars proceeded to operate, whereupon obesity and flatulence revealed themselves instead of ovarian tumor. His second case recovered ; the third died ; and in the fourth, (which I shall notice elsewhere,) the operation was abandoned, he having encountered a fibrous tumor strongly adherent.

The cases of Mr. Lizars, from their marked errors of diagnosis, set the whole surgical world in commotion, and while upon one side of the Atlantic the success and brilliancy of Dr. McDowell's operations were eagerly looked too, upon the other side, the failure of Mr. Lizar's operations gave to the English surgeons, already willing to doubt the success of Dr. McDowell's cases, room to waver, and for several years the operation slumbered.

It was the slumber, however, of a *vigorous* child, whose features seemed as if some "happy thought" of coming triumph played at its "heart-strings," when, in its strength, it would go forth, "giving beauty for ashes, the oil of joy for mourning, and the garment of praise for the spirit of heaviness."

MR. CHARLES CLAY.

In 1842, Mr. Charles Clay, of Manchester, England, — now, perhaps, the most distinguished operator in the world, — commenced his series of operations. He informs me, by letter, to which I refer you as a part of this report, that he has now operated seventy-six times, and may be read thus :

"Of first 20, 8 died, 12 recovered ;
" second 20, 6 died, 14 recovered ;
" the last 36, 9 died, 27 recovered.
First cases, 1 death in $2\frac{1}{2}$;
Second cases, 1 death in $3\frac{1}{2}$;
Last cases, 1 death in 4."

"This," says Mr. Clay, is, "I believe, the legitimate mode of viewing the question (progressively) by which the mortality is shown to be *gradually lessened* by *practical experience*."

Charles Clay was the first English surgeon to perform the operation of ovariotomy by the *long incision*, and it is said by Dr. Blundell, that "perhaps no operator in any branch of surgery

ever had such a weight of professional odds against him, as had Mr. Clay in the operation of ovariotomy."

He had triumphed, however, and his record is before you, over his own signature.

Mr. Clay is now fifty-six years old. He is reputed to be a "bold, prudent, graceful, and elegant operator in any department of surgery." At the time of his fifty-fifth operation, not less than "*eleven hundred pounds of diseased structure* had been removed from the human body in this special operation alone." It would now, perhaps, make an average of twenty-five pounds to the patient, amounting to near *two thousand pounds ! !*

Mr. Clay is now in possession of the largest obstetric library in the world, being able to quote from 2,500 authors on that subject alone; and whilst yet a student, he is said to have taken notes from 500 volumes.

In the "London Medical Circular and General Medical Advertiser," to which I am indebted for much of the information relative to Mr. Clay, I find letters from James Blundell, congratulating Mr. Clay upon his success. I will quote briefly a part of each.

Dear Sir: My cordial congratulation on your success — not the hap of lucky incident, but the well-earned result of a just mixture of enterprise, science, and exact care. A few years and I trust it will appear, *abdominal surgery is at present only in its infancy;* but, then, what an infancy! how full of bloom and promise! JAS. BLUNDELL, M.D."

Again, in another letter dated October, 1845:

"Forbe's Review I have just read. It ought not to disturb you for a moment. These men are butting their heads against a stone wall; and the grimaces they make on feeling the solidity of the materials, are as amusing as they are pitiable. Applauded by all who have honesty and intelligence enough to appreciate your efforts, you may well persevere, for to use the reviewer's own citation, it is indeed a 'high and holy undertaking.' Yours, etc., JAS. BLUNDELL, M.D.

Professor Simpson, of Edinburgh, among many others, encouraged Mr. Clay — sent him patients for his opinion, and was the *first to suggest* the term *ovariotomy*, which Mr. Clay at once adopted.

DR. WASHINGTON ATLEE.

Next in the arena of operators, in 1844, our own countryman, Dr. Washington Atlee, of Philadelphia, commenced his series of operations. He informs me by letter (which is made a part of this report,) that his operations now—March, 1854—amount to twenty-three cases.

Of first 10, 6 died, 4 recovered;
" second 13, 4 died, 9 recovered.

The profession, in this country, owe Dr. Atlee a lasting debt of gratitude for his vigorous and energetic exertions in behalf of the operation of ovariotomy. His table of cases bearing date as far back as 1701, and coming up to 1851, comprising 222 operations, then the most numerous collected in the world, must have cost him an incredible amount of labor. And this arduous task has been no less signal, than the brilliancy and success of his operations.

Dr. Atlee's " Prize Essay on the surgical treatment of certain fibrous tumors of the uterus," together with his numerous contributions to the "American Journal of Medical Science," on ovarian disease, is full of interest and instruction; and to these articles, together with the publication of his own operations in ovariotomy, we may attribute, in a great degree, the spread of the operation throughout this country.

It would be both difficult and tedious further to particularize operations in this country, however earnestly I may be induced to do so. I may say, however, and I trust with as much truth as pride, that, in the West, the operation of ovariotomy has attained as great, if not a greater degree of success, than in any part of the United States; and in Kentucky, as renowned for her surgery as for her chivalry, we have gone as far " as he who goes farthest."

Those of you who have read the report of Professor Gross on " Kentucky Surgery," must feel proud of the surgery of your State. It has kept pace with the intelligence, the agriculture, and the chivalry of her sons. And whilst the reputation of the intellect and patriotism of her statesmen is world-wide; whilst even along the classic shores of Greece,

" They mingle with their grateful lay,
Bozzaris with the name of Clay,"

you have produced the first and greatest *ovariotomist*, Dr. Ephriam McDowell; and you have produced the most renowned *lithotomist* known in any clime, Dr. Benjamin W. Dudley.

Diagnosis. "Ah! there's the rub." And when I approach the examination of a case in which a proper diagnosis is sought, I am frequently reminded of that remarkable passage in the Book of Books, "*He that thinketh he standeth, take heed lest he fall.*"

It is said by the historian, McCauley, that a "history of the *errors* and *follies* of a nation is essential to the generation which follows." So it is with ovariatomy. Its past history presents an array of errors and grave deceptions which is, perhaps, without a parallel, in mind or memory. It is said by Mr. Phillips, that the most learned men of Edinburgh examined a case with Mr. Lizars, and after agreeing that it was ovarian tumor, Lizars proceeded to operate, whereupon obesity and flatulence revealed themselves, instead of ovarian tumor.

In a second case of Mr. Lizars, the memorable case of Magdalene Bussy, a case often appealed to by opposers of ovariotomy, to show how long ovarian disease may remain harmless, Mr. Lizars attempted the operation for evarian tumor, but failed; the wound was closed up and the patient recovered. Twenty-five years after, this patient died of apoplexy. Dr. Simpson was present at the post mortem examination, and in a note to Dr. Tilt, says: "The tumor was pediculated, but fibrinous and uterine, not ovarian." In a letter to Dr. Robert Lee, after the post mortem examination, Mr. Lizars says: "Then (alluding to the time of the operation,) every one who examined her, considered the tumor ovarian and free from adhesions."*

In the case of Smith and McDowell, where the patient had tapped herself ninety times, both considered the diagnosis as certain, but on opening the abdomen, no ovarian tumor was found, but a mass of intestines matted together by adhesions.†

Dr. Lyman relates the case of Boinet, where the best surgeons were unable to decide upon a tumor. A consultation was held;

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*London Lancet, Vol. 1, 1851.

† Appendix to Cooper's Surgical Dictionary.

Among those present were Roux, Blandin, Robert Montaine, of Lyons, Recamier, Joxbert, Martin, Lolin, and others. Opinions were divided between pregnancy, extra uterine pregnancy, fœcal accumulations, encysted ovary, collection of blood in the uterus, etc. She was under observation many months, the tumor eventually disappearing after an attack of diarrhœa.

Henry Smith relates a case where an incision eight inches in length was made for the removal of ovarian tumor. Both ovaries were found to be sound, and *indurated omentum* found to be the cause.*

Prince relates a case which was pronounced to be ovarian tumor. He operated; tapped the patient; but a few drops of blood escaped; he cut and tore the part with the finger; tent introduced. In a few days the patient died. A post mortem examination was held, whereupon a large *pediculated tumor of the spleen* was found, loosely adherent to the peritoneum.†

Dr. Philip Buckner, formerly of Kentucky, to whom I am indebted for much of my early information with reference to the operation of ovariotomy, diagnosed a case as ovarian tumor; "operated by an incision of nine inches; no ovarian tumor found; but a tumor situated in the mesentery, between the lamina of the peritoneum, and surrounded by small intestines. The operation was proceeded with, the tumor dissected out, and the superior mesenteric artery and other small arteries tied. The patient recovered, and in spite of the great separation of the mesentery from the intestines, no apparent bad consequences of any kind ensued." "This," says Mr. Brown, of Edinburgh, "is the most hazardous feat of operative proceeding I am acquainted with, in which our transatlantic brother has gone ahead."

Mr. Harvey presented a case—of much interest to the London Medical Society—of supposed ovarian dropsy. Ovariotomy was determined upon, but not performed; and when the patient died, the disease was found to be an *hydated cyst*, connected with the liver, no ovavian disease whatever existing.‡

I have collected many other cases of equal interest bearing

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* Philadelphia Medical Examiner, January, 1855.

† American Journal of Medical Science, 1852.

‡ American Journal of Medical Science, October, 1852.

upon this point, but those already quoted are " proof strong as holy writ," that the diagnosis in ovarian disease has been, and still is, most wofully defective. But while I freely acknowledge the enormity of these errors, I am fully convinced that the diagnosis is yet in its infancy, and that many of these errors have and will yield to the increasing energy which is being brought to bear by many of the first men of the profession on this subject.*

It is not alone in ovarian disease that very grave and flagrant errors have been committed by distinguished surgeons. It is said that Sir Astley Cooper and Dr. Highton, of London, in a case of pregnancy, where the quantity of *liquor amnii* was so enormous as to render fluctuation distinct, appointed a day for the operation of *paracentesis*. In the mean time, the lady was taken in labor and delivered of a child.†

Mr. S. G. Goodrich, whose literary labors exceed those of perhaps, any one in this country, being the author and editor of one hundred and seventy volumes, and the father of the Peter Parley literature, was attacked with what seemed to be disease of the heart. At that period, he was obliged to be carried up stairs, and never ventured alone, being subject to nervous spasms, which threatened sudden suffocation; he went to Europe, and at Paris consulted Baron Larroque and L'Henniner, both eminent specialists in diseases of the heart. They interdicted wine, and required him to live on light vegetable diet. Afterwards, despairing of relief, he returned to London, where he consulted Sir B. C. Brodie, who decided that no organic disease existed, and that the difficulty was *nervous irritability*, and required him "to feed well on good roast beef," and " to take two generous glasses of wine " with his dinner.

Mr. Abercrombie, of Edinburgh, afterwards confirmed the opinion of Sir Benjamin Brodie.

It is now twenty-five years since this consultation occurred and Mr. Goodrich is still living, having already sold of his own writings seven million copies.‡

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* Brown, p. 196.

† Brown on Surgery, Diseases of Women, p. 196.

‡ Goodrich's Recollections of a Lifetime, p. 282.

"How often," says Dr. Buchanan, "has the operation of *lithotomy* been performed without finding a stone in the bladder, or, if found, the stone being encysted and not removed, and the operation remaining incomplete." Yet in surgery this is legitimate. In all the departments of surgery, as well as of ordinary practice, and in diseases, too, about which the profession have been writing and investigating for hundreds of years, grave and serious errors have been committed. Why not in a disease that is as yet in its infancy as to its science?

I might cite you to numerous instances in pregnancy, from the medical jurisprudence of the country, and from *obstetricians*, where serious and acknowledged errors have been committed. Indeed, I know, in my own history, of a case where two respectable practitioners deliberately examined a lady supposed to be pregnant, and who was then in the sixth month, but who declared that she was not pregnant, and that it was a foul slander upon her character. However, "murder will out," and in the course of events, a son was the result of their grave diagnosis. This same patient was under the treatment of a practitioner for several months, but, with all the poultices and hot fomentations his genius and skill could bring to bear upon the swelling, it would not go down until nine calendar months had duly elapsed.

I might enumerate many instances in the common practice of our profession, where errors in "high places" are daily committed. I will mention one from the memorabilia of my own case book.

Not long since, I was called to see Judge Morris, of Chicago, who was at that time in Kentucky. I found him jaundiced and much emaciated. He had been unwell for many months, had been treated, he said, by the faculty of Chicago, by some for a neuralgic affection of the stomach and liver, and by others for a spasmodic action of the "duct leading from the liver." He was finally advised to travel, but before reaching Cincinnati, on his way to Kentucky, was attacked in the cars. At Cincinnati he was treated by Dr. Taliaferro, who advised him to go to the Blue Lick Springs. He went there with the hope of clearing up his skin, and was there attacked again. From thence he went to Brookville, at which place I saw him, in consultation with Dr. Corlis. He was then suffering with a severe paroxysm

of pain, commencing in the right hypocondriac region, branching off to the shoulder. The pain was increased by motion, and often after a meal, pulse nearly regular; and when these irregular attacks of pain would cease, it was *all of a sudden*. It goes off like no other pain, with or without inflammation. After I had finished the examination and had a conference with Dr. Corlis, he requested me to give an opinion. I told him he was suffering from *gall stones*, passing from the liver. "What," said the patient, "a quarry in the liver?" He reminded me that each medical man whom he had consulted had a different opinion, and that he did not know whom or what to believe. I directed the nurse, when the bowels were acted upon again, to thin their contents by pouring on water, and then to pour out the contents of the vessel on a white cloth. On the next morning the nurse handed to the patient *two small pebbles* or *gall stones*, one as large as a pea, and the other the size of a grain of wheat. On my next visit I found him cheerful and "ready to render unto Cæsar the things which are Cæsar's." In a few weeks he went home. Soon after he was confined to the bench for three or four weeks, trying the well known case of Green for the murder of his wife, and was again attacked. I was telegraphed to go and see him, and, in connection with his attending physician, advised him to leave the bench. He did so, and since then married near Lexington, Ky., and is, I learn, in good health.

A correct diagnosis is the keystone of success in ovariotomy, and the care with which we trace its parts should be the landmarks—the corner trees by which we take distance and move with our compass.

Much of the illiberal opprobrium heaped upon the operation, and on operators in general, has been the result of "itching palms" for professional renown, of unmatured and hasty diagnosis, and of the difficulty inexperienced operators have had to get what information is legitimately in the hands of experienced operators. There is perhaps no disease incident to human flesh which requires so deliberate, close, and patient investigation, as that which relates to ovarian disease. A drop of water falling into a bucket is small in itself, and scarce worthy of note, but in this way the bucket may become full. So it is in the diagnosis of ovarian disease, each symptom, however minute and

seemingly of little consequence in itself, if carefully noted and properly weighed *as a whole*, will generally enable us to arrive at proper conclusions. And in this rule of action lies one of the secrets of success in ovariotomy. Show me a surgeon who in other operations may have his share of success, but who has a summary way of examining his patients, and of dispatching his operations, and I will show you one who is unsuccessful in ovariotomy.

I am fully sensible of the importance, and the difficulties we encounter in obtaining such information as will guide us in the examination of ovarian disease. Less has been written about it, in proportion to its importance, than any class of diseases known to the "healing art." I shall therefore attempt, from my own humble experience, and that of others, so to classify the symptoms and means of examination, that "he who runs may read." I may say, however, that you may meet with cases which for the time being may baffle your strongest apprehension and your most scrutinizing examination. I believe with Dr. Armstrong, "that when we find ourselves in the *dark*, it is better to stand still until the light returns," than to run the risk of going over a precipice. In other words, it is better prudently to wait for further developments. It is said that the "wise and active conquer difficulties by daring to oppose them," and in this age of wonders there is scarcely anything insuperable. I remember to have read of, or seen at some time, a picture representing a party of men, their hats and coats lying by their side, and, with pick-ax in hand, attacking the base of a mountain, whose summit towers far above their heads. We look again, and the steam-horse, as though "the speed of thought were in his limbs," follows their footsteps through the bowels of the earth.

Before commencing the examination of a patient supposed to have ovarian tumor, or dropsy of the ovaria, it is important to have the bowels and bladder emptied. If there is much tenderness or soreness in handling the tumor, it is better to give the patient chloroform, as it will enable you, without pain on her part, to conduct a more complete examination. Prior to this, however, sit quietly down, as if the day was devoted to this particular purpose, and obtain from the patient a complete history of the case. How and when the disease commenced, of

how long duration, whether painful or not, in what state the general health, whether the menstrual discharge is regular, does the tumor move from one side to the other in turning, is it, as far as you have observed, moveable at all, has it by any course of treatment diminished in size, has it any time been accompanied with swelling of one or both of the lower extremities, etc., etc.

The patient should be placed upon the back, with the extremities flexed, so as to relax the abdominal muscles. Our aim must be, in the examination, to ascertain whether the tumor is *ovarian* or not, and then its *pathological character*. In two-thirds of the cases which I have examined, I have found the tumor to commence in the right or left iliac fossa; and the patient to describe it, when first noticed, to have been as big as a hen's or goose egg. In other instances, it attains to considerable size before it is noticed. I operated on a case last summer, where the tumor attained the weight of twenty-four pounds in thirteen months. The patient did not know upon which side the tumor commenced, and was under the impression that she was merely becoming fleshy, so little was she complaining. In ovarian tumor there is generally but little disturbance of the general health. The stomach, liver, and kidneys generally maintain their usual action. So even with the menstrual discharge, except where both ovaries are diseased.

Dr. Frederick Bird has published a case, where the disease was of *sixteen years'* standing, and during *seven years* of that time the menses disappeared—operation, patient recovered.

In fibrous or scirrhus tumors of the ovaria, the menses are oftener irregular than in encysted tumors. Occasionally, you will meet with a case, where, in the early part of the disease, the patient suffers with what she supposes to be colic. At such time, if the tumor (or bowels) is *firmly pressed* upon, the pain may be traced deep down in the right or left iliac fossa. At other times, from active exercise, or exposure to a sudden change of air while exercising, a diffused soreness will be felt over the bowels. A lady (Mrs. Burns), near Marietta, Ohio, came to Augusta to consult me for the treatment of "dropsy of the bowels." Soon after her arrival, she was attacked with violent pain and great tenderness of the abdomen, so much so, that no pressure could be borne upon the bowels. She was

confined to her bed for ten days. I learned from her that such attacks were frequent, and she attributed the present one to the travel in the cars, or from the walk from the boat to the hotel. When the pain and soreness of the bowels had subsided, I made a careful examination of the case, which convinced me that it was ovarian tumor. With the exception of these occasional attacks, her general health is good, and in consequence of this fact, I have not yet operated upon her.

May these attacks not originate from the friction of the tumor against the peritoneum, causing some degree of inflammation to set in? I merely mention this case, and may, by the way, mention others, where it will illustrate a fact or corroborate a principle.

As the tumor increases in size, it maintains a rounded outline, and is uniformly dull over the region by percussion, in whatever position the patient may be placed. As it ascends from the pelvic cavity to the abdominal, it rises in front of the bowels; and in proportion as it extends to the opposite side from which it made its appearance, and spreads out over the bowels, will the dullness be observed by percussion in the same ratio. The intestines lie under or behind the tumor, whilst in ascites they float on the top of the liquid, containing, as they always do, more or less gas. In the former we have the dull sound peculiar to ovarian tumor, while in the latter the sound on percussion will be *resonant.*

The more advanced the disease, and the larger the accumulation of liquid, the *thinner* and tighter are the walls within which it is confined, and the more distinct the fluctuations. "Even when the quantity is small," says Dr. Watson, "not exceeding a few ounces, a little practice and management will enable you to detect it. Percuss with one finger the most dependent part of the cavity, and apply at the same time a finger of the other hand very near the part struck; and if l quid be there, you will perceive a limited, yet a distinct, fluctuation. In the same way, the presence of liquid in a small cyst may sometimes be ascertained."

The veins of the abdomen are increased in size and number; this, however, is not so marked until the tumor has attained considerable size.

The *uni-locular* cysts present a uniform surface, whilst the

multi-locular have an uneven and irregular surface. In the uni-locular cyst fluctuation is distinct from one side of the abdomen to the other, and generally per vaginam also; whilst in the multi-locular it is distinct only over a particular part of the abdomen, in the immediate part of that particular cyst I remember to have examined a case where fluctuation could not be felt from one side of the abdomen to the other, but was distinct in a certain space on both sides. It was not perceptible per vaginam, from the fact (as it proved afterwards) that the tumor consisted of three cysts, one occupying the pelvis, and one on either side of the abdomen. In this case, the womb was thrown back upon the rectum, (as it often is,) and the uterine sound could not be easily introduced until an assistant, standing by the side of the patient, placed his hand in front of the tumor and lifted it up with considerable force.

By this maneuver of an assistant, if we retain our finger in the vagina, and there are any considerable adhesions to the womb, or the tumor is a part of the womb itself, the womb will sometimes be lifted nearly or quite out of the reach of the finger.

When the vagina is elongated and drawn up under the arch of the pelvis, or the uterus thrown back on the rectum, with an assistant stationed as above, we will be better enabled to use the uterine sound, and push the womb from side to side, if there be no adhesions. When it is remembered that the most fatal adhesions are generally found at the base of the tumors, we can not exercise too much caution in this part of our examination. In the diagnosis of uterine, and non-uterine tumors, I have found the uterine sound, at times, indispensable. And here allow me to describe its use in its inventor's (Prof. Simpson) own language.

"It may be used in one of three ways:

"1st. The uterus may be retained in its situation, with the bougie, and then, by the assistance of the hand above the pubis, or by some fingers in the vagina, the tumor, if unattached to the uterine tissue, may be moved away from the fixed uterus.

"2d. The tumor being left in its situation, it may be possible to move away the uterus from it to such a degree as to show them to be unconnected.

"Or, 3d. Instead of keeping the uterus, both may be moved simultaneously; the uterus by the sound, and the tumor by the hand or fingers, to opposite sides of the pelvis, to such an extent as to give still more conclusive evidence of the same fact."

When the tumor is small, by introducing the middle finger into the vagina and the thumb into the rectum, we will be enabled to feel an elastic, egg-like tumor between the rectum and vagina. It is sometimes slightly painful and tender, but again there is no uneasiness manifested to the touch.

Dr. Churchill, in his Diseases of Women, says: "If the finger be introduced into the rectum past the tumor, we shall find the fundus uteri, and be able to distinguish it from the enlarged ovary. This is very necessary, or we might conclude the case to be retroversion of the womb. In addition, it may perhaps enable us to decide whether one or both ovaries are diseased."

"It should be remembered," says Dr. Brown, "that hernia may descend between the vagina and rectum, and feel like a tumor in that region; but in the absence of symptoms of strangulation, we must distinguish it from ovarian cyst by the effort of coughing and change of posture, and by being unable to pass the finger beyond the tumor."

The pressure of the tumor in the pelvic cavity sometimes gives rise to difficulty in voiding urine, torpidness of the bowels, etc. There are sometimes occasional symptoms of pregnancy, morning sickness, enlargements of the breasts, and sometimes violent pains set in, resembling labor pains. Here the stethescope is our guide, together with the time which has elapsed since the commencement of the disease. A young lady, upon whom Dr. Dunlap and myself operated, presented some of the above symptoms, and it produced no little commotion in the community among whom she lived.

There is another means of diagnosis and examination to which I invite your careful attention and cultivation. It is the sense of touch, or pressure upon the abdomen, with the ends of the fingers. If we percuss or press firmly, and in quick succession, with the ends of the fingers over an ovarian cyst, there is, at the cessation of percussion, or pressure, an elastic sensation — a rebound to the sentient extremities of the fingers — a resisting or reflecting back of the fingers, in the distended cyst; whilst in

ascites there is not the same elastic response to the finger. In fibrous tumors and enlargement of the spleen, there is a doughy, fleshy sensation to the fingers, which is more easily felt by the practiced finger than described. This mean of diagnosis requires practice of the fingers, as it does to distinguish the different shades of the pulse. Of this diagnostic sign, Dr. Watson says :

" If you press suddenly with the tips of the fingers in a direction perpendicular to the surface, a sensation which it is difficult to describe in words, yet which is quite decisive and not to be mistaken, a sensation of the displacement of liquid and of the impinging of your fingers upon some solid substance below."

The same writer further states, in reference to the senses :

" You will find what previously to positive trial you might not suspect, that the senses — the eye, the ear, the touch, however sharp or delicate they may naturally be, require a special course of training and education, before their evidence can be trusted in the investigation of disease."

Dr. Latham says, (I quote from Bennett,) with equal truth, that the " knowledge of the senses is the best knowledge, but the delusions of the senses are the worst delusions."

Swelling of the lower extremities we sometimes meet with, both in early and later stages of the disease. This originates from the pressure of the tumor upon the vessels which return the blood to the heart. See case of Mrs. Williams, of Indiana, and Mrs. Martin, of Maysville, Ky. In the latter case, ascites, swelling of the limbs, and ovarian tumor coexist.

When we have diagnosed the disease as ovarian tumor, next in importance is the extent of adhesions and the prospect of its removal. Perhaps the guide of no author is better, or the experience of any individual more to be relied upon, than that of Mr. Brown, of Edinburgh, in his tests for adhesions. After placing the patient on the back, with the extremities flexed, so as to relax the abdominal parietes, he directs the cyst to be moved from side to side. If this were readily done, he knew that there were no adhesions. He then pressed firmly over the relaxed parietes, and moved them over the cyst; if they were readily moved, he knew there were no adhesions on the upper

and lateral surfaces of the cyst. He then grasps and puckers up the parietes, and moves them over the cyst, and saw if they were gathered up readily, without raising the cyst itself. He then requires the patient to take a full inspiration, and if there be no adhesions to the extent of an inch, the place previously occupied by the tumor being taken up by the intestines, a dull sound over that region is elicited by percussion during ordinary respiration; but when the patient takes a deep inspiration, an intestinal resonance is there perceptible.

"Freedom of motion in the tumor," says Dr. Lyman "though not altogether decisive, is indicative of the absence of adhesions." It is now one of the fixed facts, that the most dangerous and insuperable adhesions are generally found at the base of the tumor, and found, too, when the tumor is easily moved from side to side. The case of Dieffenbach, Berlin, is in point. Here the tumor was movable in every direction, and partly on its own axis even; the operation was commenced, but abandoned, on account of the difficult adhesions to the vertebral column. The patient, after much difficulty, recovered.

We might, also, refer to the case of Page, where the tumor was movable, operation commenced, cyst evacuated and drawn partly out, when it was found adherent to the "surrounding parts about the pedicle, and to several inches of intestines." The operation was abandoned, and the patient died.

If I can satisfy myself (and I generally can by the uterine sound and by other means) that the adhesions at the base of the tumor are not insuperable, the immovability of the upper portion would not always deter me from an operation. See the case of Dr. Dunlap and myself, Mrs. Lastley, Portsmouth, Ohio. Twelve months before Dr. Dunlap and I performed the operation, Dr. Kimbro, of Lowell, Massachusetts, attempted the operation and opened the abdomen; but finding, as he did, a mass of adhesions at the superior part of the tumor, abandoned the operation and closed up the wound. In this case, the upper part of the tumor was immovable, but, after a careful and diligent examination by both of us, we decided that the adhesions at the base of the tumor, if any at all, were very slight. The case was successful, but required the application of twelve ligatures, to the superior adhesions, which were principaily peritoneal. It gives me much pleasure to state that this accomplished lady is now (nearly a year after the operation) in good health.

In another case of Dr. Dunlap's and mine, Mrs. Kamsey, of Winchester, Ohio, operation performed November 15, 1855, a large multi-locular tumor, weighing sixty pounds after its removal, so completely filled up the abdomen and packed itself into the pelvis, that it was impossible to ascertain the extent of the adhesions. Fluctuation, however, was distinct in each cyst, and after discharging their contents, we came upon one of several adhesions near the pedicle, which was attached to the peritoneum with a tapering neck, as it neared the tumor, so much so, that a shoulder, or button-like piece, was dissected out of the tumor to prevent the ligature from slipping off. The case did well, and the patient is now in good health.

A further test of Dr. Frederic Bird for superior adhesions, I have found to be a valuable one, namely, by putting the abdominal muscles in action, and noticing whether they rise much from the surface of the tumor. Thus, if the patient, while lying on her back, be told to raise herself up in bed without using her arms, the recti-muscles will start up into a prominent band, if their sheath is not tied down by adhesions on its peritoneal surface, but not if it is tied down.

Dr. Washington Atlee, in an article published in the American Medical Journal, places considerable reliance on the pulsation of the tumor itself, or the "aortic impulse as being more manifest in solid or encysted growths than in cases of ascites.

Before I leave this part of our diagnosis, I wish to say an additional word in reference to percussion. Among those who are expert in their perception of ovarian tumors (and they are few and far between), perhaps as much, if not more importance is attached to the use of percussion than to any other symptom or set of symptoms. We have, over the umbilical region, in ovarian tumor, in whatsoever position you place the patient, a dull sound on percussion; whilst in one or both of the flanks we have the resonance peculiar to the intestines. This diagnostic evidence is, perhaps, ninety-nine times in a hundred, correct in reference to tumors. Dr. Watson, however, gives us an anomalous case, which is a rare illustration as an exception. "The history of the case was the history of ovarian tumor;" yet, continues he, "the umbilical region, when percussed, always renders a hollow sound." Upon the death of the patient the mystery was solved: air hissed forth from the opening made by

the scalpel through the abdominal parietes, and an ovarian cyst of considerable magnitude was found adhering to the peritoneum in front of the belly, and containing no liquid, but some yellowish shreds only. This ovarian bag had been filled with air, which had given rise to the equivocal sounds. The air, it is supposed by the author, was formed from the decomposition of a degenerate cyst within.

I have alluded to the examination *per vaginam et per rectum* but perhaps not so specifically as its merits demands. You will often be enabled by the finger to detect fluctuation in a cyst, and as frequently to detect a fibrous tumor of the ovaria from a uterine one.

Allow me to cite a case: Miss Strader, formerly of Maseon, Ohio, but then of Cincinnati, came to Augusta to consult me about the propriety of an operation for what her physicians pronounced ovarian tumor. On examination I found the tumor occupying the central and right side of the abdomen. It was easily moved in any direction without any apparent pain. There was no fluctuation, and the ease with which the tumor could be lifted up and turned from side to side, made, for the moment, an impression on my mind that (although perhaps fibrous, with a narrow pedicle) it would justify an operation. But remembering my motto, which heads this article on diagnosis, "He that thinketh he standeth, take heed lest he fall," I proceeded to other tests. On introducing the finger into the vagina, I found it completely filled up with an obtuse lobe of the tumor, dipping deep down into the pelvis. At first I thought it might be retroversion of the womb, but by a rectal examination, I found a smaller lobe pressing upon the rectum, which seemed to sprout off from the lobe in the vagina in a perpendicular direction. I came to the conclusion that it was an *intra-mural* tumor of the uterus, forming in the walls, and extending both upward and inward. The patient returned home, but came back a second time, insisting still upon an operation. I wrote a note to Dr. Dunlap, who came and examined the case with me. He formed a similar conclusion to the one I have just expressed. Miss Strader was subsequently examined by Profs. Marshall and Bayless, of Cincinnati, and since then by Dr. Washington Atlee, of Philadelphia, as will be seen from the following note:

PHILADELPHIA, *Nov.* 9, 1854.

"*Dear Sir:*

Your patient, Miss Strader, presented herself to me to-day, and, upon examination, I have arrived at the same conclusion you did—that is, a fibrous tumor of the uterus. The uterus, however, can not be clearly diagnosed, and consequently as the relation of the tumor with it can not be defined, no operation ought to be recommended.

Yours, truly,

WASHINGTON ATLEE,

418 *Arch Street.*

J. TAYLOR BRADFORD, M.D."

ASCITES AND OVARIAN TUMOR.

The distinguishing characteristics of ascites as compared with ovarian tumor are important. It is not always an easy matter to distinguish between the two, and it has once occurred to me to encounter more difficulty in deciding between ascites and ovarian tumor, than it was to establish a correct diagnosis between uterine and ovarian disease.

In the maturity of both diseases, when the abdomen is distended to its utmost, many of the symptoms which assist and guide us in the early stages, are lost. The ovarian cyst then loses its circumscribed and lateral preponderance, and accommodates its growth to the inequalities and recesses of the abdominal cavity.

In the earlier stages of ascites, we generally find an equable enlargement of the abdomen on both sides, whilst in ovarian tumor the swelling is circumscribed, and confined mostly to one or the other side. In ascites there is more constant and uninterrupted tenderness of the peritoneum, by pressing firmly and quickly with the ends of the fingers, whilst in ovarian tumor it is only occasionally the case. In ascites the general health is sooner and more seriously disturbed, whereas in ovarian tumor it often remains good for months, or even years. In ascites the secretion from the kidneys is usually scant and defective, whereas in ovarian tumor, except in the rapidly enlarging cases, there is but little change. In ascites we find the patient oftener with a dry skin, thirst, and a more frequent and irregular pulse, whereas in ovarian tumor they are only occasionally, if at all,

present. In ascites we can generally trace the cause of the distension to some cardiac, renal, hepatic, or other organic affection, whereas in ovarian tumor, if of long duration, the mystery is how the patient carries twenty, thirty, forty, or even sixty pounds, without constant complaining. In ascites the bowels, always containing more or less gas, float to the surface of the fluid, whilst in ovarian tumor they lie behind or underneath the tumor. We have, then, on percussion, in ascites, whatever position the patient assumes, the resonant or hollow sound peculiar to the intestines, (which remain uppermost,) with corresponding dullness below. In ovarian tumor we have the dull sound over the region of the umbilical or latero-umbilical and latero-pubic, in whatever position the patient may take ; or, as Mr. Brown more strikingly describes it, " want of resonance in the lowest part, in all positions, with tympanitic sound in the highest, in all positions, indicates ascites."

To these characteristics, usually considered so important, Dr. Watson has given us some anomalous and interesting exceptions. In one case the distension in ascites was so great that the mesentery was not broad enough to allow the buoyant intestines to reach the surface, when the patient was supine. In this case, then, instead of the resonance peculiar to the intestines, it gave a muffled or dull sound.

The second case was found, upon post mortem examination, to be ascites, where the " omentum had formed into a thick cake," and was " strapped tightly over the subjacent intestines." Here, of course, we would have a dull sound, although ascites existed.

He alludes to another possible contingency, in which the sounds by percussion would be equally deceptive. This may occur in consequence of the " adhesion of the various coils of intestines to each other, and the parts behind them." Such cases, however, fortunately for the diagnosis of ascites, are very rare, and I do not know a single author, save that rare teacher and profound thinker, Dr. Watson, who has met with them.

I have now a patient, Mrs. Kenyon, opposite Vanceburgh, Kentucky, whose abdomen is very much distended, and the history of whose disease is purely ovarian. It has been of nearly three years' standing. The general habit is but very little disturbed, and the sound elicited by percussion over the

entire abdomen is resonant, except occasionally, when, just below the umbilicus, a thickening of the parietes, or what feels more like the "omentum cake," takes place, over which a dull sound will be elicited until it subsides, which it generally does in two or three weeks. The usual and generally approved remedies for ascites have not decreased the size of the abdomen. It is clearly, in my mind, not ovarian, but ascites; but to what may it be attributed?*

When, in either ascites or ovarian tumor, the quantity of liquid is small, fluctuation by the usual mode is not always distinct. In such cases, we will find the mode of Mr. Tarral, as detailed by Professor Wood, worthy of use. It consists in applying the thumb and middle finger of the same hand upon the surface, and percussing with the index finger between them.

The test (already alluded to) of Dr. Bird, of London, with reference to adhesions in ovarian tumor, I have found to be one among the most convincing tests in ascites; and I do not now recollect any writer who has alluded to it as one of the tests in that disease. That is, if the patient, whilst lying upon her bed, be directed to raise herself up in bed without using her arms, the fluid will bulge up prominently between, and laterally to, the recti muscles, whilst in ovarian tumor, on account of the circumscribed sac, it will not admit of such a degree of prominence. The parietes of the abdomen will admit of considerable extension, whereas the sac and the recti muscles will not admit of the same marked protuberance and inequality.

It sometimes happens that ovarian tumor and ascites exist together. I have met with one remarkable case of this kind, Mrs. Martin, of Maysville, Kentucky. By pressing firmly with the ends of the fingers, the ascitic fluid was readily displaced, and a tumor of the left ovary found floating in the surrounding liquid. The patient was sixty years old, and the disease had progressed so far, and the general health so much declined, that I did not advise or solicit an operation. She lived but a few weeks after I saw her, and no post mortem examination was obtained. In response to a circular addressed to

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* I have tapped this lady twice, and with the application of a light bandage after the second tapping, she has entirely recovered.

the physicians of Kentucky by myself, I received from Dr. Dimmit, of Lewisburgh, (an intelligent and promising physician of that place, and whose patient she had been up to the time of her removal to Maysville,) the following history of the case:

"I saw her for the first time three years ago, at which time the tumor (occupying the left side) was firm, movable, and dropsical. The disease appeared subsequent to the cessation of the catamenia. Her general health at that time was moderately good. She suffered at times extreme pain in the region of the tumor, at which time a nervous train of symptoms, resembling hysteria, set in."

I saw Mrs. Martin in one of the nervous attacks alluded to by Dr. Dimmit. She would lie for a time motionless and apparently lifeless, but would retain her consciousness throughout the paroxysm. The attacks were superinduced by pain, fright, or excitement of any kind. I merely quote this case to illustrate how unlike different persons may be affected by the same disease, and that ovarian tumor is not without its collaterals and concomitants in the nervous system.

It may appear to you that I have dwelt unreasonably long upon the diagnosis of this "hydra of calamities," and the cases cited by way of illustration may, for the time being, appear irrelevant, but these cases and these symptoms and tests, may one day meet you at the bedside.

DISEASES LIABLE TO BE MISTAKEN FOR OVARIAN DROPSY.

Dr. Brown, in his excellent work on "Surgical Diseases of Women," classes these diseases as follows:

1. Retroversion and retroflection of the uterus;
2. Tumors of the uterus—*a.* solid, *b.* fibro-cystic;
3. Ascites;
4. Pregnancy;
5. Pregnancy, complicated with ovarian dropsy;
6. Cystic tumors of the abdomen;
7. Distended bladder;
8. Accumulation of gas in the intestines;
9. Accumulation of fæces in the intestines;

10. Enlargement of the liver, spleen, or kidneys, or tumor connected with these viscera;

11. Recto-vaginal hernia, and displacement of the ovary;

12. Pelvic abscess;

13. Retention of the menstrual fluid from imperforate hymen;

14. Hydrometra.

A description of these different diseases, under their particular class in the different medical works, will generally enable you (if not possessed of the "tumor mania") to distinguish them from ovarian dropsy. I shall only allude to a few of them in which I may have had some personal experience.

From what I have read and observed, I am inclined to the belief that malignant disease of the ovary is very rare. I have met with but one case. This was a patient of Dr. Duke's, of Maysville, the wife of the Rev. M. Upon examination I found a large, uneven, but solid tumor, occupying the left side, and extending up to the umbilicus. It was particularly firm, with numerous obtuse lobes projecting upward; rather tender to the touch, and so completely adherent to the surrounding parts, particularly to the womb, that but little if any movement could be effected. An examination per vaginam revealed the same hardened and uneven surface. The pain and suffering were very great, general health bad, and that peculiar cast of countenance which indicates a system worn down by malignant disease. Soon after I saw her, I learned from Dr. Duke that the tumor had grown so rapidly, and infringed so seriously upon the bladder, that it was almost impossible to pass the catheter, which, for some time, had been the only means of passing urine. No post mortem examination was obtained.

When we add to the above symptoms that in cancerous growths, the tumor is uneven in its growth, the pain and soreness much greater than in other forms of disease, the general cachectic and sallow complexion, the peculiar hardness and rapidity of its growth, the general health and strength soon wasted, we will have but little difficulty in determining its nature.

I have already directed your attention to the case of Prince, where a patient was operated on for ovarian dropsy, which proved, upon post mortem examination, to be a tumor of the spleen.

I was once consulted in a case, Mrs. ——, of Boone County, Kentucky, which a number of physicians had pronounced ovarian. She came to Augusta. I found, upon examination, the abdomen enormously distended, the tumor reaching from the pubis to the enciform cartilage, and occupying almost the entire abdomen, without any marked preponderance upon either side. Upon pressure, a hard or doughy feel was imparted to the finger. There was no fluctuation manifest, and a dull sound was elicited upon percussion throughout the abdomen, except the right hypogastric region. The tumor was movable, and upon dipping the finger deep down between the pubis and the tumor, a "cactus-like" lobe of the tumor was felt, which could be slightly raised without any apparent pain. The symptoms generally were obscure. She complained but little except from the weight, which could not be less than twenty pounds. Examination per vaginam revealed no signs of a tumor in the pelvic cavity. But little was known about the history of the case, with the exception of the patient's avowal that it commenced on the "left side, immediately under the ribs," and was of two years' standing. The "cactus" or notched-like feel of the tumor, together with the condition of the pelvic organs, and the history of the case, led me to the conclusion that it was not ovarian disease, but enlargement of the spleen (hypertrophy.) I have since understood that the family have moved West, and have lost the history of the case.

I saw another well-marked case of diseased spleen in the daughter of Mr. ——, of Nicholas County, which had been diagnosed as ovarian tumor.

OVARIAN TUMOR — PREGNANCY CO-EXISTING.

In the Transactions of the American Medical Association, 1851, (Atlee's tables,) is a case of Dr. Atlee's, where the patient was two months pregnant at the time of operation. No miscarriage. Tumor weighed eighty-one pounds. Died of starvation.

In the Medico-Chirurgical Transactions, vol. 30, is a case of Dr. Bird, where there was no sign of pregnancy; operation performed; weight of tumor fifty pounds; abortion second day; recovered, and had a child subsequently.

In Prof. Gross' Pathological Anatomy, a remarkable case is related, as occurring in the practice of Dr. Lean, of Columbia, South Carolina. It occurred in a young lady aged twenty-five years. No alvine evacuation had been had for nine weeks. Upon a post mortem examination the intestines were found enormously distended; *colon, duodenum and ilium* measuring thirteen and one-half inches in circumference the quantity of fæcal matter amounted to nearly seven gallons.

Mr. Brande relates a case where the fæcal accumulation impacted in the colon amounted to thirty-three pounds. (Same authority.)

Mr. Brown says: "I once saw a case of simple encysted ovarian dropsy, which, in its earliest stage, was considered by a very distinguished surgeon, in London, to be accumulation of fæces."

I mention these cases that you may be on your guard, and not mistake, as some prominent English surgeons have done, fæcal accumulation for ovarian tumor.

In 1854, whilst attending the State Medical Society in Covington, Ky., I visited, with Dr. Chambers, a patient of his laboring under disease of the omentum. The abdomen was considerably enlarged, with some degree of ascites, but by displacing the liquid by percussing firmly with the ends of his fingers, that peculiar knotted or rigid feel which characterizes enlargement of the omentum was manifest. The history of the case—the point at which it first made its appearance—together with that ridged or serrated feel of transverse lines, with more pain and tenderness than is usually the case with ovarian tumor, enabled me to decide in my own mind that the disease was omental and malignant.

I have seen one case of this since, a patient of Dr. Adamson, of Maysville, Ky. The disease in this case presented the above characteristics, except that it was more uneven in surface, lumpy and knotty, with all the leading indications of true malignancy. No post mortem examination was obtained.

LETTERS FROM SURGEONS AND OPERATORS.

The following letters, which I trust will prove of much interest on this subject, have fallen into my hands in answer to inquiries in search of statistics on ovariotomy

PHILADELPHIA, *Jan.* 24, 1854.

My Dear Sir:

Your interesting letter came to hand last month, but has not been replied to, in consequence of my numerous and various engagements, and depression of spirits from domestic affliction. I regret that I shall not be able to render you much assistance in the investigation you are engaged in.

Some years ago I took a lively interest in the subject, from having carefully examined Dr. Bird's preparations in London, and from having read Clay's and other works sent me by their authors. Being, however, rather out of the line of my studies and practice, I have not recently turned my attention to the subject—not enough, certainly, to justify my offering any decided sentiments in relation to it, especially as I have never performed or witnessed the operation. The books, moreover, referred to, I forwarded some years since to Dr. John L. Atlee, of Lancaster.

In conversing a few days since with that distinguished gentleman, I took the liberty to show him your letter and to ask him for statistics. He referred me at once to his brother's (Dr. Washington Atlee) writings, which embodied everything known, he remarked, upon the subject, including Dr. Lee's statistics. These I will get and send you without delay.

I will only add that I have no prejudice to contend with in the matter. My feelings, I confess, are in favor of the operation *in proper cases;* and I would not hesitate to perform it if called upon, after due study and preparation, for I have a strong conviction, derived from my two successful cases of Cæsarean section, saving both mother and child, that little danger is to be apprehended from opening the abdomen, provided the peritoneum be carefully handled, and ordinary skill and prudence be exercised in the operation.

The views thus given I do not consider worth making known. I have no objection, nevertheless, if you think my authority in

collateral matters of any weight, that my name be used in accordance with the remarks above stated.

The case you are about to publish is certainly a very interesting one, and I shall take great pleasure in reading it.

With great respect, I am yours,

W. GIBSON.

PHILADELPHIA, *March* 27, 1859.

My Dear Sir :

Your letter was received last month, and would have had an earlier reply, but it came to hand while in the midst of building and moving. My papers even yet have not been arranged so as to enable me to give you a satisfactory answer, although I have a large mass of materials, which would go a great way toward establishing gastrotomy in the minds of the profession ; I mean those members of the profession who are influenced more by facts and truths in surgery than by opinions and prejudices.

My professional engagements are so pressing at present that I can not pretend to analyze the matter in my possession for your use. I will, however, send you several pamphlets—among them my table of cases—which will give you all the facts on record up to the date of publication. I may say, in reference to the operations occurring since the publication of my table, that the success of the operation is certainly not less than there represented. This ought to make it as justifiable and legitimate as any other capital operation in the catalogue of surgery. Indeed, I consider the arguments employed against it by the opposers of gastrotomy equally as applicable to many other operations long since established.

My own cases now amount to twenty-three. These may be divided into two classes :

First. Those where death was impending, and daily looked for ; and,

Second. Those in a more favorable condition.

In the first class were ten cases, and four lives were saved by the operation. The death of the other six was supposed not to have been hastened by it, while the comfort of all the patients was improved, and in some of the cases life was thought

to have been prolonged. In none of these could death be attributed so much to the operation as to the disease. Among the recoveries, one patient was sixty-nine years old, tumor twenty-eight pounds; another was fifty-six years of age, tumor fifty pounds; another was pregnant and the tumor was heavier than the patient; while the fourth was bloodless from flooding after miscarriage, with a small, thread-like pulse, 130 per minute. These cases, I believe, were snatched from the grave by the operations.

In the second class are thirteen cases—nine recoveries, four deaths—very nearly the same proportion as in Clay's operations.

I congratulate you and Dr. Dunlap on the success of your operations, and would be pleased to have a report of each case, as well as all other information which you can furnish me on this and similar subjects.

Please accept a copy of my prize essay, which I also forward to your address. I have operated on six cases since its publication.

Very respectfully yours,

WASHINGTON ATLEE.

MANCHESTER, ENGLAND,
December 15th, 1856.

My Dear Sir:

I have just received your kind note, dated November 23, 1856, and have to thank you for the many kindnesses therein expressed. When I wrote last to you I was busy preparing a small volume entitled "Hand-Book of Obstetric Operative Surgery" for the press, intending to follow it up by a larger work on ovariotomy, stating my experience in full. With great difficulty I found time to complete my Hand-Book (which I hope by this time you have seen,) in which you will find a long chapter exclusively devoted to ovariotomy. But I need scarcely tell you, my increasing professional engagements interfere so seriously with my time, that I can scarcely attend to any thing that I am not really compelled to; otherwise, I have abundant material to communicate to the world, which I imagine would be desirable.

I am delighted to hear of your great success, *far* exceeding even my own; indeed, I almost envy you and Dr. Dunlap, and earnestly hope for its continuance. I have not yet given up my intention of publishing my ovarian work. It is only waiting time, not inclination, to complete. In the meantime, I can only add a few particulars to my last statement of cases, which now amount to seventy-six, and may be read thus:

Of first 20, 8 died—12 recovered;
" second 20, 6 died—14 recovered;
" the last 36, 9 died—27 recovered.

I believe this is the legitimate mode of viewing the question (progressively) by which the mortality is shown to be gradually lessened by practical experience, thus:

First cases, 1 death in $2\frac{1}{2}$;
Second cases, 1 death in $3\frac{1}{2}$;
Last cases, 1 death in 4.

I should like you to refer to my new Hand-Book for such practical hints as I have, from time to time, elicited by practice, and I will write to my publisher to forward you a copy.

I am entirely of your opinion, that the cases require great care in selecting, and should not be operated upon *merely because they are ovarian.*

I have little to say as to the want of credence in those who take ground against the operation. I can, however, with pride and pleasure, refer them to many men of the highest standing in my own country, amongst them Prof. Simpson, Dr. Bennett, of Edinburgh, Dr. R. Lee, Safford Lee, and a list of hundreds who have communicated with me on the subject, as to my veracity, not forgetting Professors Lee, Z. Channing, with Dr. Atlee, in your own land.

The opposition in England to the operation is fast giving way, and I trust it may be said, that in legitimate cases there are few surgeons here who oppose it. I can not at present do more than give you this short resume.

I have some few cases under my care on which I expect very shortly to operate, and I trust I shall be as successful as I have been, if not more so.

With kind regards and best wishes for your continued success, I am, my dear sir,

Yours, most sincerely,

CHARLES CLAY, M.D.

Dr. J. Taylor Bradford, *Surgeon, Augusta, Ky., U. S.*

I regret to say that I have not received the "Hand-Book" alluded to in the above letter of Mr. Clay.

Dear Sir :

In reply to your letter of the 24th ult., I have to say that I regard ovariotomy as fairly within the precincts of regular surgery. Ohio, it should seem, holds a prominent rank in the operation. Very respectfully, R. D. MUSSEY.

Cincinnati, Jan. 1, 1857.

Extract from a letter to me by Dr. Blackman, Cincinnati, Jan. 2, 1857 :

"If you see the Western Lancet, you are probably already aware that I regard ovariotomy as a justifiable operation in suitable cases. I would not operate in a case of encephaloid disease of the ovary; and I would not persevere in an operation already commenced, should I find very extensive adhesions, for I have seen a patient, from the breaking up or rather dividing with the knife such adhesions, die on the table. I saw such a case occur to Dr. ——. I was one of his assistants."

Truly yours, GEO. C. BLACKMAN.

Dr. Bradford :

I have received yours asking for the results of my observations upon the operation for ovarian tumors. Upon this subject it is not in my power to say any thing from my own experience in favor of the operation.

Many cases in the early stages of enlargement have been under my care, wherein medical treatment removed the enlergement, and restored the health of the patients, while others of protracted existence, of malignant growth, or of complex

organization, attended by great enlargement, have offered me no evidence in favor of an operation. It is proper, however, to observe that in reference to these, my observations have been limited, as you will infer on being advised, that in a practice of five and forty years, embodying every variety of surgical practice, I have operated upon one case only. The tumor appeared to occupy the entire abdominal cavity, and was organized throughout. The patient died on the fourth or fifth day after the operation, and possibly might have recovered under the advantages of good nursing, directed by professional skill, neither of which were at command.

With great regard, very truly your friend,

B. H. DUDLEY.

Dr. J. T. Bradford, *Augusta, Ky.*

Lexington, Jan. 4, 1857.

Louisville, January 17, 1857.

My Dear Sir:

I feel that I owe you an apology for so long delaying to answer your letter of the 24th of December last. The fact is, that I have been reluctant to write on the subject to which your letter relates, because I have scarcely formed any very decided opinion on many points connected with it.

Of the propriety and necessity of ovariotomy in certain cases, I have no doubt; but to confine the cases with precision, for the guidance of those who may be debating the matter in their minds, and need to be helped to a proper decision, is, I apprehend, a difficult task. It is, I think, perfectly clear that no patient with a diseased ovary, who does not suffer much inconvenience from her malady, and is yet capable of enjoying life and contributing to the happiness of others, ought to be advised to the risk of so dangerous an operation. But, on the other hand, if the operation be deferred until life itself is a burden, the chances of its successful performance are greatly diminished, and to decide exactly how heavily this burden must press before we shall be justified in resorting to the knife, is a very nice point, and one the decision of which involves, of course, much responsibility.

Probably future and more extended experience may clear up

the obscurity that now perplexes this view, and dissipate or at least diminish other difficulties that embarrass the whole subject. At present, while I entertain the opinion that under certain circumstances the extirpation of diseased ovaria is a justifiable operation, I should feel at some loss were I called upon to decide the conditions, though I might be able to apprehend them in practice.

My own personal experience in ovariotomy is very limited, being confined to three cases. In one of these, operated upon by Dr. Dudley, many years ago, the patient survived the removal of the tumor only a few days. The second occurred in the practice of Dr. Gross, and was likewise followed by fatal termination. The third was my own case, which had a more fortunate result, the patient entirely recovering. I say fortunate, for I do not ascribe the issue to my superior skill, but purely to luck.

I might have performed the operation several times since, but I confess I have not any decided wish to repeat it, but have rather been disposed to evade it, or, as we sometimes say, dodge it.

Do not, I pray you, think me a surgical poltroon on account of this confession, but attribute my hesitation rather to the want of clear and satisfactory perception of the line of surgical duty.

Hoping that your report may enlighten me, and be alike creditable to yourself and the society,

I remain, my dear sir, your friend,

H. MILLER.

New Orleans, March 30, 1857.

My Dear Sir

Excuse me for no replying to yours of the 7th of February sooner, asking my views on the propriety of ovariotomy. Pressing business at the time it was received compelled me to lay it by, and the subject passed from my mind until now. You are perhaps aware that I am the advocate of a new method of curing ovarian dropsy, which obviates the pain and danger of ovariotomy fully as much as Civiale's method of removing stone from the bladder obviates the pain and danger of lithotomy.

But as Civiale's invention is not applicable to all cases, neither

is my method — practiced with success in one case—of treating ovarian encysted tumors, by reaching them through the Fallopian tubes, practical in all cases. Perhaps it is applicable in only a very few. You might naturally expect me to be among those who are disposed to magnify the dangers attending excision, to attract the greater attention to the discovery of a method of cure void of either pain on danger. But I am not among them. I am in favor of the McDowell operation when it offers the only chance of saving the life of the patient. I call it the McDowell operation, because he was the first surgeon to perform it with success for encysted abdominal tumors, requiring for their extirpation the whole abdominal parietes to be laid open from the sternum to the pubis. The tumor removed by Dr. McDowell, of Danville, Ky., from Mrs. Crawford, weighed fifteen pounds, and the cure was complete in about a month. The operation was performed in the year 1809, yet in 1826, the fact that such an operation had been performed with success by a physician in an obscure village in Kentucky, was not fully believed either in New York or London, although McDowell, as also the two Smiths, Nathan and Alban, had, in the meantime, performed a number of operations of the kind with success. The London medical journals sneeringly noticed McDowell's cases, which Mr. Lizars had appended to his work on ovarian disease, published in 1825. A New York physician in a monograph on the same subject, published in the Medical Recorder of Philadelphia, vol. x, p. 262–269, 1826, noticed these sneers of the London editors, and expressed a "*hope*" (italicizing the word) "to see Dr. McDowell come out well in the affair, and make good his claims."—p. 267. The editor of the Medical Recorder, Dr. Calhoun, at the conclusion of the article, assured his readers that there was no doubt in regard to the cases reported by McDowell, as he had been assured of their truth by communications of the most respectable character from Kentucky. But because some cockney editors of London chose to sneer at McDowell's cases of successful ovariotomy fifteen or sixteen years after they had been reported and duly authenticated, the New York physician seemed to think it was incumbent on McDowell to make good his claims—claims which he had already made good so far back as 1809, when he cured Mrs. Crawford, by an operation requiring an incision from sternum to pubis through the walls of the abdomen.

So long did it take truth to travel from Kentucky to New York, and so strong were London sneers against it when it got there, that Mrs. Hunt, a patient of three New York physicians, was permitted to die a miserable death without getting the benefit of that truth, her physicians looking on and giving their assent for her to suffer and die without surgical aid, with a disease which McDowell had proved to be a remediable ailment by his success with Mrs. Crawford and others. The London editor's sneers were too strong for the Kentucky editor's facts with the New York physicians, and they let her die without attempting ovariotomy to save her. On examination after death, they found no adhesions of any consequence, and "*posteriorly*" (to use their own words) "*the attachments easily yielded to the fingers, and we rolled out a huge mass almost without the aid of the knife.*" "Its attachment to the body was by two pedicles, not larger than a finger, on the original sight of the ovarium."—(p. 265.) See Medical Recorder, vol. x.

At a later period, in the year 1828, Dr. Foreman, of New Jersey, reported a case (in the Medical Recorder, vol. xiv, pp. 366 and 377) of ovarian dropsy, which he tapped a number of times, drawing off, at diffent times, upwards of twenty gallons of dark colored, viscid humor, and which, after five months suffering, terminated fatally. On examination after death, "the position of the tumor in the abdomen was found to be anterior to all the viscera, and its adhesion to them was so slight as to require the scissors in one place only to free it, when it rolled out a huge fluctuating mass upon the table."—(p. 369.)

In reporting the case, Dr. Foreman, seeing how slight the adhesions were, very correctly concludes, "that in encysted dropsies, unless the containing sack can be entirely removed from the body, or destroyed by suppuration, there is very little ground to hope that they ever can be cured by art. Therefore, when the ovarium is the seat of the disease, we are warranted by the successful results of the few operations of the kind that have been performed, in laying open the cavity of the abdomen and removing the diseased organ from it at once. If this course had been pursued toward my patient she might at this time have been living. These organs have been removed sufficiently often, without dangerous symptoms intervening, to fully justify the operation in all cases where the general health of the patient

is good, and the diagnosis clear. The appalling exposure of the viscera in this operation, should, I admit, deter from its performance, were death not inevitable ninety-nine times in a hundred without it." "Unfortunately the dread of attempting to do good for fear that evil may grow out of it, paralyzes the hands of surgeons, and satisfies them to sanction inevitable death, rather than incur the possible dangers of a timely operation. The time, however, has come when these degrading apprehensions are giving way," etc. (p. 361.)

I could not express my views on this interesting subject more clearly than Dr. Foreman has expressed them for me in the above quotation, and I beg you to receive the same as my answer to the important question, in regard to the propriety of the operation of ovariotomy, that you propounded to me. Those who are disposed to blame the New York physicians for letting the sneers of London editors paralyze their hands, so far as to sanction the inevitable death of Mrs Hunt, rather than give her a chance for her life by resorting to ovariotomy in her case, should not hold the physicians of the present day blameless, who condemn the operation under all circumstances, for no better reason than that some flippant European writers and lecturers have condemned it without making themselves acquainted with the facts contributed by American surgeons.

It is one thing to cast doubt and suspicion upon facts, and another to ignore them altogether.

Fifteen or twenty years after ovariotomy had been successfully performed in a number of cases in Kentucky and other parts of the United States, doubt and suspicion were cast upon them by European writers, and now, after the facts called in question have been proved beyond cavil or dispute, they are very much inclined to ignore them entirely, and to treat the subject as if no such operation had ever been successfully performed in America. Thus Watson, in his fourth lecture, speaking of ovariotomy, says: "The results of experience have been so discouraging, as well nigh, in most minds, to prohibit such attempts in future." Watson had evidently not informed himself in regard to the facts, or designedly ignored Dr. McDowell's and other American surgeon's successful operations. It does not follow that because the operation has been unsuccessful among the pauper and lazzaroni classes in tbe European

hospitals, that well fed Americans, surrounded with all the comforts of life, and who stand operations much better than European hospital patients, should be deprived of the chance it gives them for their lives. Both in surgery and in the practice of medicine, it is high time for America to set up for herself, and to be governed by her own experience and observation, and not by the experience and observation of Europe, drawn mostly from hospital practice. It is true that the operation of ovariotomy would be apt to kill a half starved pauper in a crowded European hospital, and so would a hasty plate of soup, a full meal, a dose of calomel and jalap, or a free bloodletting.

In the Boston Medical Journal, vol. v, p. 378, 380, Dr. Thos. Fereday, of Dodley, reported a case of ovarian tumor, spontaneously subsiding by a discharge of fluid from the vagina, estimated at from two to three gallons, in one night. In this instance, the water no doubt made its way through the Fallopian tube into the uterus, and passed out of that organ through the vagina.

A similar case is reported in the Transylvania Journal of 1829, vol. ii, p. 97, 98. The patient had taken a dose of senna, and reported to the attending physician that it had not only operated on the bowels, but that she "had urinated during the night to an amount that not only astonished but alarmed her" The next morning the ovarian tumor, a very large one, had entirely disappeared. It had evidently broken into the uterus, through the Fallopian tube, and passing out, *per vias naturales*, was mistaken for urine. The Fallopian canal, when enlarged by hydroma or other causes, affords an open way to the cavities of the serous membranes, through which fluids, extravasated in the abdomen, may find their way out. It would also give a ready outlet to the water contained in ovarian cysts. Cysts are lined with a distinct secreting membrane, sometimes single, but generally composed of smaller cysts contained within a parent, attached by narrow pedicles, and communicating between themselves. When cysts are opened from without, no matter how small they may be, a dangerous inflammation is sure to follow, which nothing can cure but an entire destruction of the secreting surface by suppuration or by total excision.

Hence no cases of ovarian dropsy, which have been treated

by puncture from without, have recovered, so far as my observation extends. I have seen the operation tried under the most favorable circumstances, and always without success.

No inflammation followed in the case in which I drew off a large quantity of gelatinous fluid by probing the Fallopian tube. The woman entirely recovered, and has since had a number of children.

The other two cases above mentioned, where the ovarian tumor spontaneously disappeared in one night under the excessive discharge of water from the natural passages, also entirely recovered. This new operation of reaching the cyst through the Fallopian ducts, is decidedly preferable to any other in cases which will admit of the fluid being reached in that manner. The operation is neither difficult nor painful, when the tube is sufficiently open to admit a small sized probe.

In a lady who was subject to a profuse discharge occasionally from the vagina, supposed to be leuchorrhœa, I have several times passed a small sized catheter into the Fallopian tube. After gaining the cavity of the uterus, the catheter was passed very readily and without pain to so great a distance as to demonstrate, beyond a doubt, that it was far up in the Fallopian tube. It was only during the period of those aqueous discharges that I succeeded in passing it with facility to a distance that proved it to have passed beyond the cavity of the uterus. I am aware that ovarian tumors, besides the aqueous, semi-gelatinous, meliceritous, and atheromatus matter, contain, in many instances, hair, teeth, fleshy substances and bones. Evacuating the liquid contents through the Fallopian tubes, it is very probable would cause the more solid, scirrhous, or sarcomatous materials to liquify, and to escape in the same way. In the case that I reported, a mass of hard matter, as large as the fist, could be felt in the ovarian region, which continued for a year or more before it finally disappeared. When I first operated she was fully as large as a pregnant woman at her full time.

Ovarian pathology mocks at all the learning of the schools. Who can account for a *dens sapientia* in the ovarium? Yet Dr. Archer, of Maryland, found a tooth of that character in the ovarium of a patient of his. See Medical Repository, vol. xii, p. 365. New York. 1859.

A great many other cases are recorded in varions works on

good authority, not only of hair, bones, and teeth being found in the ovaria, but, in some instances, of teeth set in on alveolar process, and in one case of bones in the ovarium of a child ten years old.

Too little attention is paid to facts derived from American fields of experience, and too much importance is attached to the dogmas and opinions of book-makers and teachers in the large cities of Europe. They are mostly opposed to ovariotomy, because of the ill success which has attended it in Europe, and are slow to believe that inexperienced country physicians, in the backwoods of America, have been more successful than their most experienced and dexterous surgeons of their large hospitals. The error lies in their not taking into consideration the vast difference between the unfortunate people of Europe, living in an abnormal condition, scarcely one in a thousand occupying the position in society that nature intended him or her to fill — the sickly, infirm, and half-famished masses being compelled to overtask themselves to pamper to the luxuries of a few, whom luxury is enervating; and the more fortunate American people, living in a normal condition, all classes of society, men, women, and children, and negroes, occupying the position that nature intended for them, each having as much liberty as comports with the happiness, morality, prosperity, and comfort of the whole. Until due allowance is made for the difference of circumstances between the people of despotic Europe and those of the model Republic of the New World, the writers and teachers in London and Paris will find difficulty in believing that a physician in the little town of Augusta, in far distant Kentucky, has been engaged in seven successive operations for ovarian dropsy, all proving successful, when their most successful surgeons have failed in five cases out of seven.

Many good meaning men, who have tried to probe the Fallopian tubes, both in the dead subject and the living, without success, would sooner believe that I had made a mistake and got no farther than the cavity of the uterus, than concede that a surgical operation had been performed, which Prof. Jackson and others of less note have regarded as impracticable, forgetting that the practicability or impracticability of the operation depends upon the circumstances of the case and not upon any remarkable skill of the operator — forgetting, also, that disease

can work such changes in the Fallopian tubes as to give sufficient capacity to admit the hand, much less a probe. When the medical men of Europe take a lesson in politics and learn the important truth, what a normal government, by diffusing the blessings and comforts of life among all classes of society, can do in enabling the citizens thereof to bear surgical operations, that nine out of ten of the half-starved, over-worked subjects of abnormal governments would die under, they will be prepared to give due weight to the facts that American operators have contributed to surgery, and not before.

Respectfully, your obedient servant,

SAM'L A. CARTWRIGHT, M.D.

Dr. J. Taylor Bradford, *Augusta, Ky.*

I have other letters of much interest in favor of the operation, the authors of which are unwilling that they should go to the society in their present shape. They are mostly, however, confirmatory of the propriety of the operation, not statistical.

It is a singular fact, that in this country the operation of ovariotomy belongs almost exclusively to "Young America." So, too, in England and France, few of the elder surgeons are found operating, but rather seem to have reversed that lucky maxim which Dean Swift practiced and taught, "That because he had spent a part of his life in leaving undone the things which he might have done, he would not throw away the remainder in despair."

No one thing, perhaps, has done more to prejudice the older surgeons against the operation than the blunders and errors of Mr. Lizars. And where errors and injudicious operations are committed by great men, we are too apt to regard the thing, as in itself, hopeless under the same or similar circumstances. Is it not a fact, then, with the diminishing fatality of the operation, that many, very many, of the elder surgeons, without due investigation and reflection that the *ovary* is neither essential to the life or the health of the patient, declined to operate or countenance the legitimacy of the operation, because men equally or more renowned than they had failed — not, perhaps, from the manner in which the operation was performed, but

selection of cases — from the undeveloped means of a proper diagnosis.

No one skilled in the selection of cases would have taken more than one out of the four cases operated on by Mr. Lizars; and their failure, because of his high position, for a time, rendered the operation palsied in all Europe.

You will observe in the letter of our distinguished countryman, Prof. Mott, of New York, addressed to me in 1854 (and I hope it will not be considered uncourteous in alluding to it by way of illustration,) that his prejudice to the operation is the result of the loss of two cases of his own, and of four which came under his observation. "In no one of these cases," says he, "was the tumor over fifteen pounds," whilst in his own cases one weighed six pounds, and the other ten.

Now let us examine for a moment these cases. It is a well settled principle, that rarely, if ever, in the early stages of ovarian tumor, is the constitution or the general health much disturbed. Why operate, then, where the tumor had only attained to six or ten pounds? The danger is greater, whilst the necessity of the operation is less.

My reading and study of the cases of the most successful operators, as well as my own experience, have taught me that there are two extremes in the time at which we should operate, both of which should be avoided. The one is where the tumor is small; the other, where the operation has been delayed so long that the size of the tumor and the decline of the general health render it hazardous to operate. In the first place, I hold that in proportion to the increased size of the tumor (all other things being equal) will its pressure upon the adipose substance about the parietes of the abdomen produce its absorption, and the friction of the tumor against the peritoneum accustom it to that usage which renders it less sensitive, and less liable to take on inflammation.

The same principle holds good in pregnancy — in the earlier stages of it, before the womb has filled the abdomen, abortion, miscarriage, or premature labor (accidental or superinduced) is known to be more dangerous than at the full period of utero gestation.

I have now been engaged, directly or indirectly, in nine operations, all but one of which have been successful, and yet the smallest tumor weighed twenty-four pounds, the largest sixty.

There is, then, in this operation, as in most other things, a "happy medium," which, if arrived at, will insure the greatest degree of success.

I might cite an instance in the West similar to that of Prof. Mott, where the failure and errors of leading surgeons hover yet, like an incubus, over the operation, but it might seem like the child reproving the parent from whom he had received valued lessons too sacred to be cancelled.

There are other operations which have been much more fatal than ovariotomy, yet they are regarded as legitimate.

When the ligature was tied around the innominata the ninth time, with a fatal effect in every case, Dupuytren attempted it the tenth time with the same result. And after it had been performed the thirteenth time, all ending in death, the celebrated surgeon, Mr. Liston, whose dictum characterized ovariotomy as "belly ripping," attempted the ligature of the *arteria innominata* with the same fatal result. And yet the same surgeon, with many others, legalize this operation up to the sixteenth failure, without one case of success. Yet ovariotomy, with her increasing triumphs, is condemned!

In Mr. Merriman's list of twenty-three cases of Cæsarian operations (London Lancet, vol. i, 1851, p. 319,) comprising all the operations in the British Islands, from 1738 to 1820, in but one case did the mother survive the operation, and we find among the operators the names of John Hunter and John Bell.

Mr. Radford, in a subsequent report, says: "But two out of fifty cases of Cæsarian operation, which occurred in Great Britain and Ireland, have recovered from the operation." And what is strange, one of these two, the first case ever operated on successfully to the mother, was operated on with a razor by an Irish midwife, Mary Donnelly.

Mr. Solly says that deaths from ovariotomy up to 1846 were only one in 3½. Dr. Atlee makes the mortality only 26½ per cent.; Dr. Robert Lee, over 37 per cent.; Mr. Phillips, over 39 per cent.; Dr. Cormack, over 38 per cent.; Dr. Ashwall's table, over 36 per cent.; Dr. Lyman, in his table, says three-fifths of the operations are unsuccessful. Mr. Churchill says, "undoubtedly the mortality is very great, but a mortality nearly, if not quite as great, is not considered a fatal objection to other operations." "If," says he, "we take the major amputations of the

limbs (primary and secondary,) it appears that in Paris, according to Malgagne, the mortality is upwards of one in two; in Glasgow, it is one in 2½; in the British hospitals it is one in 3½." As to amputation of the thigh, Mr. Syme observes, "the stern evidence of hospital statistics shows that the average frequency of deaths is not less than from sixty to seventy per cent.; of 987 cases collected by Mr. Phillips, 435 proved fatal, or 44 per cent.

Mr. Curling states, on referring to a table of amputations performed in the hospitals of London from 1837 to 1843, "I find 134 cases of amputation of the thigh and leg, of which 55 were fatal, giving a mortality of 41 per cent." Of 201 amputations of the thigh, performed in Parisian hospitals, and reported by Malgagna, 126 ended fatally. In the Edinburgh hospital 21 died out of 53. Even if we take much larger numbers we find the mortality very high. Dr. Inman has collected 3586 cases of amputation generally (primary and secondary) from accident or disease, and the deaths are one in 3 1-10. In 4937 cases published by Mr. Tennick, the mortality is one in 3 1-15.

The result of the amputation at the hip-joint is still more unfavorable. Mr. James Cox has shown that, out of 84 cases, 26 were successful, and 58 unsuccessful.

Again: take operations for hernia, Sir. A. Cooper records 36 deaths in 77 operations, and Dr. Inman 260 in 545.

Or, the ligature of large arteries, of which Mr. Phillips has collected 171 cases, of which 57 died; Dr. Inman 199 cases, of which 66 died. Of 40 cases of ligature of the subclavian artery, 18 proved fatal; the ligature of the innominata has been fatal in every case.

So that, taking the mortality of Dr. Lee's estimate, it is not higher in ovariotomy than in that of other operations, which are admitted to be justifiable notwithstanding.

I might, with equal propriety, refer you to the comparative statistics of Prof. Simpson, Dr. Atlee, and Dr. Buchanan, together with many others, but I trust the present are sufficient to convince you that the operation is not such a monstrous innovation on the dignity and legitimacy of surgical practice as some are wont to teach.

OPERATIONS IN KENTUCKY.

The following is, I believe, a complete collection of all the cases which have been operated on in Kentucky up to the present date. Some of them, you will see, are without any detail, notwithstanding I have addressed circulars, as well as private letters, to the operators. Those of them contained in Dr. Lyman's report, I shall, for the sake of convenience, copy as condensed by him, the object being merely to give the leading characteristics of each particular case:

1. BUCKNER.—Mrs. W.—Two solid tumors felt through the abdominal parietes; the upper very moveable; the other wedged in the pelvis, and felt through rectum and vagina; operation June, 1848; incision from umbilicus to within an inch of symphisis; pedicle of the upper tumor attached to the lower, ligated, and removed; pedicle of lower tumor originating in the left Fallopian tube; ligature around the diseased left ovary; pedicle of tumor ligated in four equal parts; no adhesions; died sixth day of peritonitis.

2. BUCKNER.—Aged thirty-nine; several children; operation January 31st, 1850; incision eight inches; numerous adhesions; ligature around the pedicle; tumor of the right ovary removed; ligature felt thirty-ninth day; alarming symptoms, but the patient eventually recovered.

3. BLACKMAN.—Tapped several times; operation December 22, 1855; adhesions slight; ovarian tumor of twenty-two pounds removed; no bad symptoms after; recovered.

4. BUSH.—Not published; no report; died.

5. BAYLESS.—Mrs. Dredden, age 31; operation September, 1849; disease of seven years' standing; tapped seventeen times; incision ten inches; numerous adhesions, particularly around the tapping point. There was no distinct pedicle on either side, to guide the application of a ligature. It was all a confused mass. Tumor multi-locular; weight eighteen pounds besides the tappings; ligature fell at the end of the eleventh month; recovered.

6. BRADFORD, J. J.—Not published; no report; died.

7. BRADFORD, J. TAYLOR.—Miss H., Mayslick, Ky., single, aged 21; twelve years growth, having commenced at nine years of age, after scarlatina; menses appered at twelve and continued regular; variety of treatment; health failing; operation June 14, 1853; incision eighteen to twenty inches, between ensiform and pubis; adhesions to omentum; cyst tapped, extracted, and double ligatures passed through the pedicle left ovary; forty-one pounds, containing, attached to inner wall, bony plate, varying in size from a pin's head to a saucer, with one large piece of bone embedded in the wall of the sac; up the sixteenth day; ligature fell sixth week; recovered.

8. BRADFORD, J. TAYLOR.—Miss M., Milford, Ky., age 20; menses regular; thirteen months' standing; progress rapid; never tapped; operation June 4,

1856; incision ten inches; tumor very vascular; cyst originated on broad ligament half inch from left ovary; ovary healthy and of normal size; ovary removed with cyst; no adhesions; tumor weighed twenty-four pounds, double ligature passed through pedicle; ligature fell fourth week; recovered.

9. Craig.—Mrs. H., age 26; one child; menses at 15; at 16 had suppression from cold, and never regular after; complicated with ascites, which disappeared several times under treatment; operation April 22, 1854; tentative incision three inches, extended to scrobiculus; adhesions previously diagnosticated; tapped cyst; found contents too thick to pass through canula; adhesions to omentum and mesentery; double ligature through pedicle; left ovary; recovered in seven weeks; solid parts eleven and three-quarter pounds.

10. Dunlap.—Mrs. B., age 37; five children; one year's growth; tapped four times in last six months; operation March 24, 1853; incision from umbilicus to pubis, twelve inches; adhesions slight; cyst evacuated; solid portion size of child's head; evacuated; double ligature to pedicle; thirteenth day walked across room; ligature fell in three weeks; left ovary; thirty-seven pounds; recovered.

11. Prof. B. Dudley.—Not published; no report; died.

12. Dudley, E. L.—Not published; no report; died.

13. Dudley, E. L.—Not published; no report from operator; operation abandoned; patient recovered.

N. B. Received report from Dr. Dudley, April 7, too late for report.

14. Evans, A.—Not published; no report from operator; patient died.

15. Evans, A.—Not published; no report; recovered.

16. Gross.—Miss D., age 22; menses regular; eighteen months' growth; tapped three gallons three weeks before; operation June 19, 1849; incision three inches above umbilicus to pubis, one foot; right ovary; adherent, red, and vascular; ligature around the pedicle, which was narrow, and though tied with "great firmness," it came off after removal of the tumor; a large artery was secured, and another ligature applied around the pedicle, and one of the divided bands of adhesions, which showed a disposition to bleed, was ligatured also. The menses appeared for two days, the thirteenth day, and though the case looked promising, she died in four weeks of peritonitis: enclysted tumor nine pounds.

17. Miller.—Age 37; four months' growth; tapped previous week; operation April 6, 1848; incision, umbilicus to pubis; adhesions; two of the cysts tapped to reduce the size; tumor drawn out, and single ligature passed through pedicle; tumor removed, and remaining vessels of broad ligament secured separately; weight nine pounds and a quarter; last ligature came away thirty-first day; recovered.

18. McMillen.—Not published; no report; died.

N. B. Promised report, but did not receive it.

19. McDowell.—Mrs. Crawford; operation December, 1809; incission on left side, three inches from and parallel to rectus: nine inches long; ligature around pedicle; tumor opened, and fifteen pounds of gelatinous substance removed pedicle divided and sac extirpated; whole weight twenty-two pounds and a half; in five days, the report says, she was able to make her own bed, and in twenty-five days she went home.

20. McDowell.—Negress; after three or four years of mercurial treatment incision was made as in previous case; adhesions to bladder and uterus preventing its removal; the tumor was incised and gelatinous matter, and a quart of blood escaped; recovered from the operation; in two years the tumor was as large as ever.

21. McDowell.—Incision in linea alba, an inch below umbilicus to within an inch of pubis; ligature around pedicle; incision extended two inches above umbilicus, and a "scirrhus ovarium," weighing six pounds removed. She was well in two weeks, with exception of the ligature, which fell in five; recovered.

22. McDowell.—April 1, 1837; incision as in last case; ligature slipped, followed by profuse hemorrhage; vessels tied separately; some of them were cut through by the ligature finally passed a ligature around the pedicle again, and stitched it down; recovered from the operation, but was not in good health afterwards.

23. McDowell.—Operation May 11, 1829; had been under the treatment for others for eighteen months, with supposed ascites; treatment continued awhile; she was then tapped, and thirteen quarts of gelatinous fluid removed; in two months tapped again; and then discovered the tumor; in a few months was tapped the third time, when the incision was enlarged sufficiently to introduce a finger, to settle the diagnosis; tapped a fourth time, shortly before the operation; length of incision not mentioned; tied the pedicle, also a band of eterine adhesions, and removed the tumor; left ovary; died in three days of peritonitis.

24. McDowell.—Fifty-five years of age; operation 1822; incision six inches in linea alba; bloody serum gushed out and continued to flow until the sac was emptied; edges of the womb approximated by interrupted sutures; the adhesions to the peritoneum being of such a character as to induce an abandonment of the operation; wound healed at the end of five weeks; patient lived twenty years after the operation; enjoyed good health. President Jackson was present at this operation, and the details were furnished Dr. Gross by Dr. James Overton, who was present at the operation.

25. McDowell.—Miss Plasters; operation May 12, 1823; incision whole length of linea alba; finding the tumor so large that it could not be removed entire, the sac was punctured. The morbid mass was then lifted from its bed, a ligature having been previously cast around its footstalk, or uterine attachment; the edges of the wound were carefully closed in the usual manner, and the woman put to bed; for fifteen days after the operation there was a bloody, putrid discharge from the wounds, supposed by Dr. McDowell to be sloughing of the omentum. Patient entirely recovered. Dr. Gross is indebted to Dr. W. C. Galt, for many years a distinguished practitioner of Louisville, for the details of this case.

26. Smith, A. G.—Age 30; two children; menses regular; operation May 24, 1823; incision, umbilicus to within an inch of pubis; no adhesions; sac emptied of several pints of "watery matter," and with some difficulty extracted; ligature around the pedicle; right ovary of "scirrhus appearance;" menses returned profusely in five days; ligature fell twenty-fifth day; has been well since, except for pain in loins and abdomen during menstrual periods

28. Smith.—Case successful. (Cooper's Surgiacl Dictionary.)

29. SMITH.—Patient died of secondary hemorrhage from relaxation of the ligature some days after the operation. (Cooper's Surgical Dictionary.)

30. SMITH & MCDOWELL. — Patient had ascites, for which she had tapped herself ninety times. Both considered the diagnosis as certain, but, on opening the abdomen, no ovarian tumor was found; a mass of intestines only, conglomerated by adhesions. She died.

ANALYSIS OF KENTUCKY CASES.

It will be observed in the detail of the Kentucky cases, that many of them are incomplete in prominent points of statistical interest. In the eighth case of Dr. McDowell, five of which were published by himself, in but one is it stated whether the right or left ovary was the seat of disease, whether any were fibrous, etc.

Others again have failed to give the duration of the disease, whether married or single, whether they had borne children or not, age, etc.

In consequence of this omission on the part of those who have reported the cases, and the failure of others to report the unpublished cases as solicited by me, it will be impossible for me to give you any thing like a complete analysis of them. I have stated the result of some of the unpublished cases on reliable authority, and if, in any instance, it is incorrect, it will be no less a regret to me than to the operator. I will note some of the leading points of interest so far as I have been able to get them.

Out of thirty operations performed in Kentucky, nineteen recovered and eleven died, nearly two-thirds being successful.

Of the thirty operations for the removal of the tumor, it was completed in twenty-five; in five it was not completed.

Of the five cases in which the tumor was not removed, two recovered and three died.

In the five cases where the operation was abandoned, the cause of the failure is reported in but two, one from adhesions to the bladder and uterus, and one from peritoneal adhesions.

In one case (No. 30) no tumor was found: "a mass of intestines conglomerated by adherions," accompanied by ascites.

In one case (No. 30) the patient tapped herself ninety times.

In but four cases is the cause of death given; three were from peritonitis, and one from hemorrhage.

In twelve cases, so far as stated, there were adhesions, or one in every two and a half.

In but two cases was the short incision practiced.

In one case (No. 8) the cyst formed on the broad ligament, and not in the ovary, weighed twenty-four pounds.

In one case (No. 9) accompanied by ascites.

In case No. 5 the ligature did not fall until the eleventh month.

(No. 5) disease of seven years' standing.

(No. 7) disease of twelve years' standing.

(No. 7) disease commenced three years before the menstrual discharge occurred.

(No. 7) contained a large piece of bone embedded in the sac with numerous particles of bony excrescence on the anterior superior part of the sac.

(No. 7) the disease commenced at nine years of age.

It seems in the three hundred cases reported by Dr. Lyman, that this case of mine (No. 83 of his table and No. 7 of Kentucky cases,) was the earliest period at which the disease commenced; and, on page 127 of his report, he alludes to it doubtingly, and says, if the "account may be relied on." I have no idea that Dr. Lyman made this allusion with any uncharitable intention, and I have no rebuke to offer, further than to reassert its correctness, and that the family physician, Dr. B. C. Duke, of Mayslick, Ky., and the mother of the young lady will bear testimony to the fact. But further: two years ago I saw a little girl in Utopia, O., four years old, whose abdomen was wonderfully distended. She walked about, but tottered as she went. She complained but little, except from over-exertion or the influence of cold, when there would be some tenderness or soreness of the bowels. The general health was good, and in strange contrast with the enormity and extent of the disease, for I believe then the contents of the abdomen would have weighed twenty pounds. On examination of the tumor, I found it filling up every part of the abdomen, fluctuation was distinct, percussion was dull at every point, except on the opposite side to which she was lying, near the spine.

I learned from the mother that one year before, she observed a swelling as large as a goose-egg in the right groin. She complained more then than since; continued to enlarge, inclining

for some months to the right side, until one day, in her own language, the "swelling was all over her bowels." To me it was a clear case of ovarian tumor. I have never met with one of which I was surer. I advised tapping and intended to follow it with iodine injections, bandage of Mr. Brown, etc.; but, for a time, the family postponed it. In the meantime they removed to Cincinnati, since which time, with all my curious interest in the case, I have not been able to hear one word.

In the New York Journal of Medicine, 1854, may be found a case of Mr. Cox, where a "healthy nursing infant" died of convulsions; the ovaries were found dropsical.

Mayor*—a case of a child seventeen days old, where the ovaries were dropsical.

London Lancet, vol 2, 1845, p. 120 (report of Royal Society of London 1805,) Mr. Charles Pedro reports a case where the ovaria were found wanting. Patient died at twenty-nine years of age.

Since circumstances noticed in preface induced me to change the character and material of this report, I had intended to report the cases of Dr. Dunlap and myself in detail, but as this report has already gone beyond my calculation, and as three of our operations are noticed in the Kentucky cases, and others of ours and my own, casually alluded to by way of illustration in the chapter on diagnosis and elsewhers, it were now seemingly useless.

It might seem that these cases were picked or selected, as peculiarly adapted to the operation. This may be true to some extent. Let us examine:

In one, Miss Harrisson, No. 7, of Kentucky cases, one of Kentucky's most distinguished surgeons, a name that was "mightier" than "Elam, the chief of our mite," sent this interesting young lady, in the bloom of youth, to her friends, there to "shuffle off this mortal coil," *as a hopeless case.*

After the operation she returned home from Augusta to her parents. Not long after I chanced to meet her on board a steamboat on the Ohio river. I never shall forget that bounding step and *weeping face*, which moved my heart by the testimonies of her gratitude: and if there be anything which invites the

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*Lyman.

love and ambition of the generous heart, or inspires an emotion worthy of our glorious triumphs in science, it is that of bearing "healing on our own wings," of giving "beauty for ashes, the oil of joy for morning, and the garment of praise for the spirit of heaviness."

In another case, Mrs. Lastley, of Portsmouth, Ohio, *Dr. Kimbro*, of Lowell, Massachusetts, a surgeon of considerable notoriety, *opened the abdomen*, and finding the adhesions, as he thought, insuperable, closed up the wound, and *abandoned the operation*. Dr. Dunlap and I, one year after, examined the case patiently, deliberately, and carefully, and *operated successfully*. See page —. In the one of these two cases the disease was of twelve years' standing, and the tumors weighed *forty-one pounds*. In the other the tumor weighed *fifty odd pounds*, and required twelve ligatures to the adhesions.

It may save reflection here to state (that contrary to the positive agreement made by Dr. Dunlap and myself whilst in partnership,) we attempted the removal of an apparently justifiable (if any are) case of *fibrous* tumor of the *uterus* in a patient in Iowa, (*not ovarian tumor*) which proved unsuccessful. I did not see the patient until the morning of the operation, but through the imploring treaties of the patient and the attending physicians, as well as some recent published cases of the successful removal of the uterus, Dr. Dunlap was prevailed upon to take the case. I am as much responsible as he, and I mention this case because the bad as well as the good cases in surgery should be known, and to steel you to adhere to your opinions if well founded, independent of those who are not so responsible.

I have but little desire to indulge in idle speculation about the propriety of the operation; facts and figures are to decide the question, and if, by a principle of arithmetic, addition, multiplication and subtraction, we give to each fact and figure its proper bearing, the answer will come out right. The opposers of Ovariotomy argue as though the improvements in diagnosis were finished, and the safest mode of operating had gained its acme. When the electric fluid was conducted from the cloud by the kite of Dr. Franklin, it did not stop there, or, but for a time, and now we find it leaping from city to city as the medium of conversation. Soon its submarine currents will relate to us

the transactions in all Europe an hour ago. The great propelling power, which was first discovered escaping from the "mouth of a tea-kettle," was first applied to river steamers, now it "moves like a thing of life" over the Atlantic. And so every improvement has been gradually developed from one degree of perfection to another.

If you will examine the *statistics* since 1850, but more particularly since 1853, you will find, by comparison with previous operations, that the mortality has diminished, and why? Simply by the better developed state of the *diagnosis*, and the improved means of operating. The operation in itself is said by some to be a simple one. I have never viewed, or found it so; there are innumerable difficulties which sometimes arise, which not one in ten of the medical books, not even Mr. Brown, in his late work on the "Surgical Diseases of Women," hints at. It will be found by the statistical tables of Dr. Atlee and Dr. Lyman, that about twenty-five per cent. die from hemorrhage. How many writers or operators can you summon, who regard the *condition* of the *pedicle when the ligature is applied as a matter of any consideration*, whether it should be upon the stretch, or how? I have met with but one in my reading, Mr. Solly, and none in my intercourse who at first sight so regarded it. The pedicle, but more particularly the *ligament* of the *ovary* is very *extensible* and *elastic*. If the tumor be lifted out with much force, or by any movement which places the pedicle on the stretch, so much so, that it does not contract before the ligature is applied, that part of it which is most extensible when it does contract, is apt to slip through the ligature, and still, without close examination, look as though all was right. Once on turning the stump of a pedicle up to see if it was bleeding, I saw a part of the pedicle contracting within the ligature. I reflected much about this circumstance, and not until I read Mr. Solly's case, did I fully understand it. (London Lancet, vol. 1846, p. 442.) Many cases, I have no doubt, died from this cause. Prof. G. W. Bayless' Missouri case, Mr. Brown's, and many others, struck me as losing their lives from this cause. I hoped to speak of some of the leading features of the operation, it is now out of my power.

In conclusion, I have to say to the Medical Association, that it will be recollected by some of its members that most of my

leisure time for two entire years was devoted to the collection and classification of statistics on Ovariotomy. But a few weeks before the meeting of the Convention, Dr. Lyman, of Boston, published a circular report embracing about the same number of cases, and as his cases and mine were gathered from the same sources, I was driven to the necessity in the very short time, to write the present report, or fail to make one.

This is all the apology I have to make for the report as you find it, trusting that your "generosity will forgive what your good sense may see amiss."

APPENDIX TO REPORT.

AUGUSTA, KENTUCKY, NOVEMBER, 1859.

NOTE.—Up to the above date, I have either operated, or been jointly connected in *eleven operations* for *ovarian Tumor*, all but *one* of which *have proved successful*, and that one, not ovarian disease, but a *fibrous disease* of the *uterus*.

The record of the most successful surgeons, both in Europe and in this country, shows a loss of *one patient* in every *four*. There are now *ten of these eleven* patients living, and, I believe, without exception, in good health. Two of these patients have, each, had two children.

The smallest tumor of the eleven patients weighed twenty-four pounds, the largest sixty. Three of these patients were young ladies, unmarried, nineteen, twenty, and twenty-one years of age. One of the three lives in Woodville, Mississippi. The tumor weighed forty-one pounds—was operated on in 1854—has since married and has had two children, both boys.

The oldest of the married patients was sixty, and the tumor weighed sixty pounds. In one of these patients, a case not yet published, the *cyst* formed from the broad ligament, close to the ovared, but not of the ovared, and the tumor weighing twenty-four pounds, with the *ovared* in its normal state, was removed together—which specimen I have carefully preserved in my office.

I feel that these statements, although implying a success not yet attained, perhaps, by any one else, is due, not only to the claims of Medical Science, but to the advocates of the operation, and to myself—not because of individual triumph or advancement, but from the fact, that at different periods in Kentucky, as elsewhere, the legitimacy and propriety of the operation has been questioned and assailed with a vehemence and vindictiveness finding, perhaps, no parallel in any other capital operation.

J. T. B.

Owing to the financial condition of the State Medical Society, the Committee on Publication, to whom was referred this report, originally published it in the "Louisville Medical News."